HEALTH HISTORY

Date _____

Name _____

Date of Birth _____ Age _____

General Health _____

Are you currently or have you ever been treated for:

Yes	No	Condition	Explain
☐	☐	Asthma	
☐	☐	Bleeding Disorders	
☐	☐	Blood Pressure	
☐	☐	COPD	
☐	☐	Diabetes	
☐	☐	Ear/Sinus	
☐	☐	Fainting	
☐	☐	Gastro-Intestinal Problems	
☐	☐	Heart Disease	
☐	☐	Kidney Disease	
☐	☐	Learning Disorders	
☐	☐	Menstrual Problems	
☐	☐	Musculo-Skeletal	
☐	☐	Psychological/Psychiatric	
☐	☐	Seizures	
☐	☐	Sickle Cell Disease	
☐	☐	Sleep Disorders	
☐	☐	Stroke	
☐	☐	Surgery	
☐	☐	Thyroid Disease	
☐	☐	Serious Injury	
☐	☐	Other	

List all medications you are currently taking. Include over-the counter drugs and herbal supplements.

Do you need to take medication during the school day? If yes, please complete the reverse side of this form.

Medication	Dosage	Reason

Allergies

Parent Signature _____