FORM B

STUDENT HEALTH HISTORY FORM

TO BE COMPLETED BY PARENT OR GUARDIAN. **(UPDATED 6/2022)**

Student's Full Name: _____ Gender: M F

Birthdate: _____ Ethnicity: _____

EXPLANATIONS

Daily Medications Yes No

Names of Medications_____

(Include those taken at home. If taken at school, a medication permission slip must be completed)

Physical Restrictions Yes No _____

Diagnosis of Asthma Yes No _____

Wheezing/Cough during or after play Yes No _____

Does student carry an inhaler to school: Yes No Does student require an epi pen for allergies? Yes No

Allergies Yes No Type_____

Life Threatening Yes No _____

Birth Defects Yes No _____

Developmental Delay Yes No _____

Dental: Braces Bridge Plate Other _____

Eye/Vision Problems Yes No _____

Glasses/Contacts Yes No _____

Ear/Hearing Problems Yes No _____

Heart Problems/Shortness of Breath/
Heart Murmur/High Blood Pressure Yes No _____

Dizziness or Chest Pain w/exercise Yes No _____

Diabetes Yes No _____

Seizures Yes No _____

Blood Disorders, Hemophilia,
Sickle Cell, Other Yes No _____

Neurological Problems Yes No _____

Bone/Joint Problems/ Injury Yes No _____

TB skin test positive (past or present) Yes No _____

Serious Injuries/Illness/Hospitalizations Yes No (Age) _____

Surgery Yes No (Age)_____

Other Concerns _____

Information on this form may be shared with appropriate personnel for health and educational purposes.

_____ _____

Date Parent's Signature