

# HIS STUDENT HEALTH FORM

## 1. FAMILY

Student's Full Name \_\_\_\_\_

Last

First

Middle

Home Address \_\_\_\_\_

Birth Date \_\_\_\_\_ Current Grade \_\_\_\_\_ Male/Female \_\_\_\_\_

Parents' Names \_\_\_\_\_

## 2. MEDICAL HISTORY

**Allergies:** Please check if your child has the following allergies.

Asthma : N/Y If yes, please explain to what degree your child has asthma and the plan of care, medicines included:

\_\_\_\_\_  
\_\_\_\_\_

Foods : N/Y If yes, please explain \_\_\_\_\_

Medicines : N/Y If yes, please explain \_\_\_\_\_

Pollens or flowers: N/Y If yes, please explain \_\_\_\_\_

Insect bites or animals: N/Y If yes , please explain \_\_\_\_\_

**General Medical:** Please explain if your child has any of the following:

Longterm illnesses or medical problems \_\_\_\_\_

Physical Handicaps \_\_\_\_\_

Special Emotional Needs \_\_\_\_\_

Are your child's immunizations up to date? No \_\_\_ Yes \_\_\_ Please provide dates, including all boosters:

- Hepatitis A \_\_\_\_\_
- Hepatitis B \_\_\_\_\_
- Typhoid \_\_\_\_\_
- Tetanus (DPT) \_\_\_\_\_
- Polio \_\_\_\_\_
- Measles (MMR) \_\_\_\_\_
- Hemophilus B (HIB) \_\_\_\_\_

Does your child wear corrective lenses for vision? No \_\_\_ Yes \_\_\_ If yes, please indicate type of lenses:

\_\_\_\_\_

Dose your child take any medications regularly? No \_\_\_ Yes \_\_\_ If yes, please give name of drug, dose, and reason for medication: \_\_\_\_\_

\_\_\_\_\_

## Parent/Guardian Release

I hereby give school staff and associated health care personnel permission to render appropriate medical care to my child in the event such need arise: while he/she is in attendance at school or on school sponsored activities. In case of an emergency, I can be reached at telephone number \_\_\_\_\_ or alternative phone number \_\_\_\_\_.

\_\_\_\_\_

( Parent Signature)

\_\_\_\_\_

(Date)

**Please attach a photocopy of immunization records with this application.**