

Health History

Child's Name: _____

Please circle any illnesses your child has had:

Asthma Chicken Pox Measles Mumps
Scarlet Fever Strep Throat Pneumonia Epilepsy
Whooping cough Rheumatic Fever

Other: _____

Allergies (food, drug, insect bites, etc.) List type, symptoms, and treatment required:

Copy of immunization record attached and signed by doctor ___Yes ___No

Date of last medical exam: _____

Please list any surgeries, accidents, chronic illnesses or other health problems in the past 2 years: _____

List any special needs (physical or other): _____

List any foods not to be given to your child: _____

List any medications he/she is currently taking: _____

Do they need to be given during school hours? _____

Parent's Signature _____ Date _____