HEALTH HISTORY

Student Name _____ Date _____
Last First Middle

Date of Birth _____ Male _____ Female ____ Place of Birth _____
City & State

Address _____ Phone _____
Street City Zip

Father _____ Mother _____

Has you child ever had an IEP done? Yes _____ No ____ If yes, please briefly describe results:

_____

_____

Does your child have any life-threatening medical condition that would necessitate a school staff member administering medication, injection or other treatment to prevent death? _____

Describe: _____

_____

Significant Health Problems	Facts to know is case First Aid treatment is necessary such as bee sting, allergy, epilepsy, diabetes, etc.
Vision Difficulty/Wears Glasses	
Hearing Difficulty	
Speech	
Emotional	
Bones or Joints	
Convulsions or fainting	
Diabetes	
Allergies	
List any medications that are taken on a regular basis	