

STUDENT HEALTH HISTORY
To be completed by parent or guardian

Student's Name _____ **School Year 2010-2011**

School: Bethany Lutheran **Grade:**_____ **Birthdate:** _____

Doctor's Name:_____ **Phone:** _____

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 (Describe)_____

Diagnosis of Asthma Yes No _____

Wheezing/Cough during or after play Yes No _____

(DOES STUDENT CARRY INHALER WITH THEM TO SCHOOL) 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 Yes No (Age)_____

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