Student Health History Questionnaire

Student Information

Full Name

Date of Birth

Grade

Parent/Guardian Name

Phone Number

Email Address

Medical History

Has the student ever had any of the following? (Check all that apply)

- [ ] Asthma
- [ ] Diabetes
- [ ] Seizures
- [ ] Allergies
- [ ] Heart Condition
- [ ] Other

If selected any, please provide details

Has your child had any operations, hospitalizations, or serious injuries?

- ( ) Yes
- ( ) No

If yes, please describe

Allergies & Medications

Does your child have any allergies?

Yes

No

If yes, please list

Does your child take any medications (including inhalers, insulin, epi-pen, etc.)?

Yes

No

If yes, please list name and dosage

Other Health Information

Are there any activities your child should not participate in?

Other health concerns or information the school should know