Confidential Health History to be completed by parent: Name _____

The health of children greatly influences their ability to learn. Please complete each item below and take this form to your physician at the time of your child's exam.

Has your child EVER had: (Please check, explain and date if yes	No	Yes	Explanation
Allergies (food, medications, hay fever)			
Anemia (low blood iron)			
Arthritis			
Asthma			
Bladder/Kidney problem or injury			
Blood Pressure Problem (High or Low)			
Bee Sting Allergy			
Chicken Pox			
Congenital Defect			
Convulsions/Seizures/Epilepsy			
Diabetes			
Ear Problems/Hearing Loss			
Encephalitis			
Eye Problems/Vision Loss/Glasses/Contacts			
Fainting Spells			
Head Injury/Concussion			
Headaches/Migraines			
Heart Problem/Murmur/Chest Pains			
Hernia			
Injury to the spleen or other organs			
Infectious Mono/Hepatitis			
Fracture-dislocation bones/joints			
Joint sprain/ligament tear/muscle pull			
Loss of a paired organ			
Meningitis			
Menstrual cycle (normal)			
Nose fracture/nose bleeds (frequent or severe)			
Pneumonia			
Rheumatic Fever			
Scarlet Fever			
Stomach Ulcer			
Tuberculosis			
Whooping Cough			
Illness lasting more than one week			
Hospitalized overnight			
Medications on a daily or prn basis at home			
Medications/inhalers during school hours/sports			
Surgery/operation			
Presently under a doctor's care for any reason			

Has any family member under 50 years of age died of a heart problem? Please Explain _____

Are there any special problems related to his/her health?_____

_____

I acknowledge that the above information is correct: _____ _____

Parent Signature Date