

**School Health Services Health History and Contact Information**  
**School Year 2008/2009**

**STUDENT NAME:** Last \_\_\_\_\_ First \_\_\_\_\_ MI \_\_\_\_\_  
**ADDRESS:** \_\_\_\_\_ **DOB:** \_\_\_\_\_ **GRADE:** \_\_\_\_\_  
**HOME PHONE:** \_\_\_\_\_ **HOME EMAIL:** \_\_\_\_\_  
**SPONSOR'S NAME:** Last \_\_\_\_\_ First \_\_\_\_\_ Rank \_\_\_\_\_  
**DUTY STATION:** \_\_\_\_\_ Work Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_  
**SPOUSE'S NAME:** Last \_\_\_\_\_ First \_\_\_\_\_  
**SPOUSE'S WORK PHONE/PLACE:** \_\_\_\_\_ Cell Phone \_\_\_\_\_  
**SIBLINGS:** (NAME/AGE/GRADE/SCHOOL) \_\_\_\_\_

**EMERGENCY CONTACT #1:** \_\_\_\_\_ **Phone #:** \_\_\_\_\_  
**EMERGENCY CONTACT #2:** \_\_\_\_\_ **Phone #:** \_\_\_\_\_

**STUDENT HEALTH HISTORY**

YES / DATE	NO	COMMENTS
<input type="checkbox"/>	<input type="checkbox"/>	ADD/ADHD _____
<input type="checkbox"/>	<input type="checkbox"/>	ASTHMA _____
<input type="checkbox"/>	<input type="checkbox"/>	CHICKEN POX _____
<input type="checkbox"/>	<input type="checkbox"/>	CANCER _____
<input type="checkbox"/>	<input type="checkbox"/>	DENTAL PROBLEMS _____
<input type="checkbox"/>	<input type="checkbox"/>	DIABETES _____
<input type="checkbox"/>	<input type="checkbox"/>	EAR INFECTIONS _____
<input type="checkbox"/>	<input type="checkbox"/>	EMOTIONAL PROBLEMS _____
<input type="checkbox"/>	<input type="checkbox"/>	HEARING PROBLEMS _____
<input type="checkbox"/>	<input type="checkbox"/>	HEART PROBLEMS _____
<input type="checkbox"/>	<input type="checkbox"/>	HOSPITALIZATIONS _____
<input type="checkbox"/>	<input type="checkbox"/>	KIDNEY/BLADDER PROBLEMS _____
<input type="checkbox"/>	<input type="checkbox"/>	LUNG PROBLEMS _____
<input type="checkbox"/>	<input type="checkbox"/>	MUSCLE/BONE PROBLEMS _____
<input type="checkbox"/>	<input type="checkbox"/>	SEIZURE DISORDER _____
<input type="checkbox"/>	<input type="checkbox"/>	SPEECH PROBLEMS _____
<input type="checkbox"/>	<input type="checkbox"/>	STOMACH PROBLEMS _____
<input type="checkbox"/>	<input type="checkbox"/>	VISION PROBLEMS/GLASSES _____
<input type="checkbox"/>	<input type="checkbox"/>	OTHER _____

**ALLERGIES**

\_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

**LIST ALL CURRENT MEDICATIONS  
 DOSE & TIMES:**

\_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

**LIST ANY CONDITIONS THAT MAY  
 AFFECT YOUR CHILD'S ACTIVITY  
 AT SCHOOL:**

\_\_\_\_\_  
 \_\_\_\_\_

*\*\* Medications at school - Students may not carry medications during the school day. If your child must take medication at school, the medication MUST be brought in the original prescription container with the Hold Harmless Form completed by the **Parent and the Physician**.*

**Check here if you want to discuss confidential information with the school nurse.**  **Yes**  **No**  
**Additional Parent Comments:** \_\_\_\_\_

**ALL ABOVE INFORMATION IS CORRECT AND COMPLETE.  
 I WILL NOTIFY THE SCHOOL OF ANY CHANGES IN MY CHILD'S HEALTH CONDITION AND ALL CHANGES  
 IN ADDRESS AND PHONE NUMBERS FOR MYSELF AND MY EMERGENCY CONTACTS.**

\_\_\_\_\_  
 [PARENT SIGNATURE] [DATE] April 08.