REQUIRED for **all** students.
RETURN this form to school.

STUDENT GENERAL HEALTH INFORMATION

Do you consider your child to be in good health? ❑ Yes ❑ No ❑ **U**nknown
Comments ____________________

Does your child have any serious illnesses/medical conditions? ❑ Yes ❑ No ❑ U
Comments ____________________

Has your child had any type of surgery? ❑ Yes ❑ No ❑ U
Comments ____________________

Is your child allergic to any medicine or food? ❑ Yes ❑ No ❑ U
Comments ____________________

Are your child's eyes checked at least once a year? ❑ Yes ❑ No ❑ U
Comments ____________________

Does your child have a dental checkup at least once a year? ❑ Yes ❑ No ❑ U
Comments ____________________

Do you feel your family has enough to eat? ❑ Yes ❑ No ❑ U
Comments ____________________

List any medications your child currently takes

Medication Name	Dose *(mg, mcg, ml, tsp, etc.)*	When & How Often *(**example**: every morning, daily at noon, with meal, etc.)*

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BIOLOGICAL FAMILY HISTORY

Are there any <u>immediate biological</u> family members who have had the following?

(U=Unknown)

Condition	Yes	No	U	Who	Comments
Childhood hearing loss	❑ Yes	❑ No	❑ U	Who	Comments
Nasal allergies	❑ Yes	❑ No	❑ U	Who	Comments
Asthma	❑ Yes	❑ No	❑ U	Who	Comments
Tuberculosis	❑ Yes	❑ No	❑ U	Who	Comments
Heart disease (before age 55)	❑ Yes	❑ No	❑ U	Who	Comments
High cholesterol (takes meds)	❑ Yes	❑ No	❑ U	Who	Comments
Anemia	❑ Yes	❑ No	❑ U	Who	Comments
Bleeding disorder	❑ Yes	❑ No	❑ U	Who	Comments
Dental decay	❑ Yes	❑ No	❑ U	Who	Comments
Cancer (before age 55)	❑ Yes	❑ No	❑ U	Who	Comments
Liver disease	❑ Yes	❑ No	❑ U	Who	Comments
Kidney disease	❑ Yes	❑ No	❑ U	Who	Comments
Diabetes (before age 55)	❑ Yes	❑ No	❑ U	Who	Comments
Bed-wetting (after age 10)	❑ Yes	❑ No	❑ U	Who	Comments
Obesity	❑ Yes	❑ No	❑ U	Who	Comments
Epilepsy or convulsions	❑ Yes	❑ No	❑ U	Who	Comments
Alcohol abuse	❑ Yes	❑ No	❑ U	Who	Comments
Drug abuse	❑ Yes	❑ No	❑ U	Who	Comments
Mental illness/depression	❑ Yes	❑ No	❑ U	Who	Comments
Developmental disability	❑ Yes	❑ No	❑ U	Who	Comments
Immune problems, HIV, AIDS	❑ Yes	❑ No	❑ U	Who	Comments
Tobacco use	❑ Yes	❑ No	❑ U	Who	Comments

Additional family history

____

____

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PAST HISTORY

Does your child currently have, or has you child ever had any of the following? *(U=Unknown)*

Chickenpox	❑ Yes	❑ No	❑ U	When? *(estimate)*	Month:	Year:
Frequent ear infections	❑ Yes	❑ No	❑ U	Comments		
Ear or hearing problems	❑ Yes	❑ No	❑ U	Comments		
Nasal allergies	❑ Yes	❑ No	❑ U	Comments		
Eye or vision problems	❑ Yes	❑ No	❑ U	Comments		
Asthma	❑ Yes	❑ No	❑ U	Comments		
Bronchitis, bronchiolitis	❑ Yes	❑ No	❑ U	Comments		
Pneumonia	❑ Yes	❑ No	❑ U	Comments		
Heart problem or murmur	❑ Yes	❑ No	❑ U	Comments		
Anemia or bleeding problem	❑ Yes	❑ No	❑ U	Comments		
Blood transfusion	❑ Yes	❑ No	❑ U	Comments		
HIV	❑ Yes	❑ No	❑ U	Comments		
Organ transplant	❑ Yes	❑ No	❑ U	Comments		
Malignancy	❑ Yes	❑ No	❑ U	Comments		
Bone marrow transplant	❑ Yes	❑ No	❑ U	Comments		
Chemotherapy	❑ Yes	❑ No	❑ U	Comments		
Frequent abdominal pain	❑ Yes	❑ No	❑ U	Comments		
Constipation requiring doctor visit	❑ Yes	❑ No	❑ U	Comments		
Recurrent urinary tract infections and problems	❑ Yes	❑ No	❑ U	Comments		
Congenital cataracts/ Retinoblastoma	❑ Yes	❑ No	❑ U	Comments		
Metabolic/genetic disorders	❑ Yes	❑ No	❑ U	Comments		
Cancer	❑ Yes	❑ No	❑ U	Comments		
Kidney disease or urologic Malformations	❑ Yes	❑ No	❑ U	Comments		
Bed-wetting (after age 5)	❑ Yes	❑ No	❑ U	Comments		
Sleep problems/snoring	❑ Yes	❑ No	❑ U	Comments		
Chronic or recurrent skin problems (ex: acne/eczema)	❑ Yes	❑ No	❑ U	Comments		
Frequent headaches	❑ Yes	❑ No	❑ U	Comments		
Convulsions or other neurological problems	❑ Yes	❑ No	❑ U	Comments		
Obesity	❑ Yes	❑ No	❑ U	Comments		
Diabetes	❑ Yes	❑ No	❑ U	Comments		
Thyroid/endocrine problems	❑ Yes	❑ No	❑ U	Comments		
High blood pressure	❑ Yes	❑ No	❑ U	Comments		
History of serious injuries/ fractures/concussions	❑ Yes	❑ No	❑ U	Comments		
Use of alcohol or drugs	❑ Yes	❑ No	❑ U	Comments		
Tobacco use	❑ Yes	❑ No	❑ U	Comments		
ADHD/anxiety/mood problems/depression	❑ Yes	❑ No	❑ U	Comments		
Developmental delay	❑ Yes	❑ No	❑ U	Comments		
Dental decay	❑ Yes	❑ No	❑ U	Comments		
History of family violence	❑ Yes	❑ No	❑ U	Comments		
Sexually transmitted infection	❑ Yes	❑ No	❑ U	Comments		
(Girls) Has had first period	❑ Yes	❑ No	❑ U	Age at first period		
(Girls) Problems with periods	❑ Yes	❑ No	❑ U	Comments		
(Girls) Pregnancy	❑ Yes	❑ No	❑ U	Comments		

Any other significant problem(s)? ____