

Last Name _____ **First Name** _____ **Gender** _____ **Date of Birth** _____

HEALTH HISTORY

Is your child having any of the following problems?

	Yes	No		Yes	No
Allergies – Medication	<input type="checkbox"/>	<input type="checkbox"/>	Allergies - Food	<input type="checkbox"/>	<input type="checkbox"/>
Allergies – Bee Sting	<input type="checkbox"/>	<input type="checkbox"/>	Allergies – Other (identify below)	<input type="checkbox"/>	<input type="checkbox"/>
Hay fever	<input type="checkbox"/>	<input type="checkbox"/>	Asthma	<input type="checkbox"/>	<input type="checkbox"/>
Wheezing, shortness of breath	<input type="checkbox"/>	<input type="checkbox"/>	Heart disease/defect	<input type="checkbox"/>	<input type="checkbox"/>
Epilepsy/Seizures	<input type="checkbox"/>	<input type="checkbox"/>	Migraines/headaches	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	Hypoglycemia	<input type="checkbox"/>	<input type="checkbox"/>
Vision problems	<input type="checkbox"/>	<input type="checkbox"/>	Hearing problems	<input type="checkbox"/>	<input type="checkbox"/>
Speech problems	<input type="checkbox"/>	<input type="checkbox"/>	Eczema or frequent skin rashes	<input type="checkbox"/>	<input type="checkbox"/>
Other Health Issue(s)/Physical Limitations/Restrictions (please explain)				<input type="checkbox"/>	<input type="checkbox"/>

If you answered Yes to any of the above, please indicate below the severity & specific nature:

Is your child regularly taking any medications? Yes (explain below) No

If yes, what medication? _____

Reason for medication? _____

**Sign
Here** →

Parent Signature _____

Date _____

RESTRICTIONS

If restrictions are requested/recommended, signature of the examining health official is required.

Is there any defect of vision, hearing, or other condition that medically requires specific seating or other action?

Yes No. If yes, please explain.

Should the student's activity be restricted because of any physical defect or illness? Yes No

If yes, please check appropriate area and explain degree of restriction.

Classroom Playground Gymnasium Swimming Pool Competitive Sports Other

Examiner's Signature **Date** **Examiner's Name (print/type)** **Degree/License**