Haysville Public Schools U.S.D. 261
Health History

Last Name: _____ First Name: _____ Grade: _____

Family Physician: _____ Phone: _____

Family Dentist: _____ Phone: _____

Is student under physician's care at this time? _____ If so, explain: _____

_____

_____

Does student have a history of any of the following? (Please be specific)

_____ _____ ADD/ADHD (**diagnosed by Physician:** Yes _____ No _____) Required medication: _____
YES NO _____

_____ _____ Allergies (if YES, check below)
YES NO Food: _____ **(requires doctor note)**
Insect bites/stings: _____ **REQUIRES EPI-PEN??** Yes _____ No _____
Environmental: _____
Animals: _____
Medication: _____

_____ _____ Asthma (**diagnosed by Physician:** Yes _____ No _____) Required medication: _____
YES NO _____

_____ _____ Bone/Muscle conditions: (include fractures and scoliosis) _____
YES NO _____

_____ _____ Chicken Pox: Date of Disease _____ Vaccine Date _____
YES NO

_____ _____ Chronic Ear or Throat Infections (Explain): _____
YES NO _____

_____ _____ Diabetes: (**date diagnosed by Physician:** _____) Required medication: _____
YES NO _____

_____ _____ Emotional conditions: (Explain) _____
YES NO Required medication: _____

(See back of form for additional questions and signature)

_____ _____ Fainting: (Explain) _____

YES NO Has student ever experienced a sudden loss of consciousness? Yes _____ No _____

_____ _____ Frequent Headaches: _____ Migraines: _____ Required medication: _____

YES NO _____

_____ _____ GI/Stomach conditions (Explain):_____

YES NO Required medication: _____

_____ _____ Head injuries or major accidents of any kind (Explain): _____

YES NO _____

_____ _____ Heart, blood disease or high blood pressure (Explain): _____

YES NO _____

_____ _____ Hearing Loss: Degree of impairment: _____ Uses hearing aide: _____

YES NO _____

_____ _____ Physical Handicap (Explain): _____

YES NO _____

_____ _____ Seizure Disorders: **(date diagnosed by Physician:** _____) Required medication: _____

YES NO _____

_____ _____ Severe Menstrual Cramps: Required medication: _____

YES NO _____

_____ _____ Urinary/Bowel Condition (Explain): _____

YES NO _____

_____ _____ Vision: Glasses _____ Full time _____ Part time _____ Contact lenses _____

YES NO Eye surgery (Explain): _____

Other Health Information: _____

_____

_____

HEALTH HISTORY: Health information will be shared with selected school personnel on a need to know basis.

_____ _____

Signature of Parent or Guardian Date