Tri County Public Schools
Health History Form

STUDENT'S NAME:_____BIRTHDATE:_____

Lives with:_____ Mom Dad Guardian

Information provided by:_____ Mom Dad Guardian

Today's Date _____ Grade _____ Female Male

PLEASE CHECK THE FOLLOWING HEALTH CONCERNS THAT APPLY:

☐ **ALLERGIES**

- Medicine: _____reaction_____
- Food:_____ reaction_____
- Environmental:_____reaction_____
- Allergy Action Plan signed by doctor for school
- Epi-Pen to be kept at school

☐ **ASTHMA**

- Asthma Action Plan signed by doctor for school

☐ **VISION**

- contacts
- glasses

Date of last exam_____

☐ **HEARING**: hearing loss, describe _____

☐ **DIABETES**

- Diabetes Action Plan signed by doctor for school

☐ **HEART PROBLEMS** list _____

☐ **EATING/DIGESTION PROBLEMS**: _____

☐ **MUSCLE/JOINT/BONE PROBLEMS**: _____

☐ **KIDNEY/BLADDER CONCERNS**: _____

☐ **SEIZURES:** type _____ frequency _____ medication _____

- Seizure Action Plan signed by doctor for school

☐ **ADD/ADHD**

- on medication, list_____

☐ **MENTAL CONCERNS**: list _____

☐ **HEADACHES/MIGRAINES**: frequency _____ treatment _____

☐ **PAST SURGERIES** _____

☐ **PAST MAJOR ILLNESSES/INJURIES** _____

☐ **MEDICATIONS**

- taken at home, list _____
- taken at school, list _____
- Prescription from doctor for medications taken at school

☐ **OTHER HEALTH CONCERNS OR INFORMATION**_____

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