East Allegheny School District
Health History Form

Child's Legal Name *(Last, First, Middle)* Date of Birth Grade Homeroom

If your child has experienced any of the following medical conditions, please enter month, day and year in the space provided:

CHICKEN POX: _____________
SEIZURE DISORDER: _____________
RHEUMATIC FEVER: _____________
HEART PROBLEMS/MURMER: _____________
NERVOUS DISORDER: _____________
T.B. CONTACT: _____________
KIDNEY INFECTION: _____________
DIABETES: _____________
BLADDER/URINARY PROBLEMS: ______________
CONCUSSION/HEAD INJURY: _____________
CEREBRAL PALSY: _____________
FRACTURES: _____________
ADD/ADHD: _____________
BLEEDING PROBLEM: _____________

ASTHMA: _____________ If yes, does child use an inhaler? ☐ Yes ☐ No

OTHER MENTAL AND/OR PHYSICAL DISORDERS (Please specify):

____

____

Please indicate below if your child has a:

FOOD ALLERGIES Yes ☐ No ☐
(If yes, please specify) _____________ _____________ _____________

MEDICINE ALLERGIES Yes ☐ No ☐
(If yes, please specify) _____________ _____________ _____________

Does Child have a prescribed allergy medication (s)? If so, provide specific information:

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Is your child receiving any treatment or medicine at the present time? ☐ Yes ☐ No If yes, please explain:

____

Please indicate if your child wears glasses, contact lenses, hearing aid(s), has tubes in ears or has any other assistive device:

____

Has your child had any serious injuries, illnesses or operations? ☐ Yes ☐ No If yes, please explain:

____

Does your child require any special services? ☐ Yes ☐ No If yes, please explain:

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If your child is restricted from physical activity of any kind, please indicate and explain: ______________________________

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Is there anything special you wish for us to know about your child?

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______________________________ ____________________

Parent/Guardian Signature Date

Revised 9.19.18