



Student Health Form

Student's Name _____ Date: _____

Personal Medical History

(Please indicate öyesö or önoö if you have had any of the following; if answered öyesö please explain)

Asthma _____	Allergies _____
Diabetes _____	Chicken Pox _____
Tuberculosis _____	Poor Vision _____
Hearing Loss _____	High Blood Pressure _____
Heart Problems _____	Adverse reactions to medications _____
Sexually Transmitted Diseases _____	(List these Meds) _____

List any other health problems that the school should be aware of: _____

Immunization Record

(State Month and year of immunization or attach a copy of your immunization record)

DPT or DT _____ (diphtheria, tetanus, pertussis)	TOPV _____ (oral polio)
Rubella _____ (3-day measles)	Rubella _____ (7-day, hard measles)
Mumps _____ (please indicate if given in combined vaccine)	Tuberculin skin test date _____ Results _____
Hepatitis B _____	HiB _____

Other vaccinations: _____

REQUIREMENT-ALL Medications must be declared.

List any medications taken regularly, dosage, times taken per day and reason for taking:

Medication	Dosage	Times Per Day	Reasons for Taking
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Other Health Information

Any known food or other allergies? _____

Family physician name and phone number: _____

In case of an Emergency? Name _____ Relationship _____
Home Phone Number _____ Work Phone Number _____
Health Insurance Company Name _____ Policy Number _____

*As always student's health information will remain private and confidential