Student Health History

STUDENT HEALTH INFORMATION: TO BE COMPLETED BY THE PARENT(S)

NAME OF STUDENT ____

PARENT'S NAME ____ _________________

FAMILY DOCTOR ____CITY ________________________ PHONE______________________________

Medical History: PLEASE CHECK ANY OF THE FOLLOWING YOUR CHILD HAS or has had:

_____Diabetes
_____Polio
_____Whooping Cough
_____Epilepsy
_____Pneumonia
_____Measles (regular - 10 day)
_____Heart Disease
_____Chicken Pox
_____Rheumatic Fever
_____German Measles (3 day)
_____Mumps
_____Scarlet Fever
_____Tuberculosis
_____Tuberculosis Contact
_____Asthma

_____Allergies - Explain: ____

_____Other (i.e., nosebleeds) ____

Operations or other serious restrictions: ____

____

Have any special recommendations been made by your physician concerning the school life of this child? _________________

____

Has he/she ever worn glasses? ___________________________ Does he/she at this time? _____________________________

Has he/she ever had a hearing loss? ______________________If so, explain____

Are there any physical conditions requiring special attention: ____

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____

Is your child on any special medications? (Please list medications and reasons needed.)

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Does your child have any needs or concerns Woodland Christian School should know about? ___________________________

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◆ **BOTH THIS HEALTH FORM AND THE CALIFORNIA SCHOOL IMMUNIZATION RECORD MUST BE COMPLETED** ◆