



# The Whole Learning School

Individualized Learning • Special Needs • Small Classes

## STUDENT HEALTH HISTORY

To be completed by Parent/Guardian each school year

Student's Name \_\_\_\_\_ Sex \_\_\_\_\_ Birthdate \_\_\_\_\_ Grade \_\_\_\_\_

This information is requested in order to provide appropriate health services for your student. It will be treated as private data and recorded in the student health record. It will be shared with those working with your student on a "need to know" basis and with emergency personnel in case of an emergency.

Does your student have any chronic health conditions? (Please ✓ all that apply.)

- |  |  |   |
|--|--|---|
| <input type="checkbox"/> ADHD/ADD          | <input type="checkbox"/> Asthma: <input type="checkbox"/> needs daily meds at school;                                    |   |
| <input type="checkbox"/> Allergies:        | <input type="checkbox"/> <input type="checkbox"/> exercise induced; <input type="checkbox"/> seasonal related to allergy |   |
| <input type="checkbox"/> Medication        | <input type="checkbox"/> Autism  | <input type="checkbox"/> Heart Condition        |
| <input type="checkbox"/> Food, List: _____ | <input type="checkbox"/> Behavior Concerns   | <input type="checkbox"/> Hearing Impairment     |
| <input type="checkbox"/> Bee Sting         | <input type="checkbox"/> Bleeding, Blood disorder  | <input type="checkbox"/> Neurological           |
| <input type="checkbox"/> Seasonal          | <input type="checkbox"/> Cancer  | <input type="checkbox"/> Orthopedic - Scoliosis |
| <input type="checkbox"/> Latex             | <input type="checkbox"/> Diabetes  | <input type="checkbox"/> Seizure Disorders      |
| <input type="checkbox"/> Arthritis         | <input type="checkbox"/> Emotional Concerns  | <input type="checkbox"/> Vision Loss            |
|  | <input type="checkbox"/> Headaches   | <input type="checkbox"/> Other _____            |

Explain \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Has your student been hospitalized or treated in the emergency room for any of the above conditions in the last year? Yes \_\_\_\_\_ No \_\_\_\_\_

If yes, explain \_\_\_\_\_

Is your student's physical activity limited in any way? Yes \_\_\_\_\_ No \_\_\_\_\_

If yes, explain \_\_\_\_\_

Does your student take any medications? Yes \_\_\_\_\_ No \_\_\_\_\_

(All medications at school must be administered within school procedure guidelines.)

<u>Name of Medication</u>	<u>Frequency</u>	<u>For treatment of:</u>
_____	_____	_____
_____	_____	_____
_____	_____	_____

Immunizations given within the last year:

_____	_____	_____
TYPE	Month/Day/Year	TYPE
_____	_____	_____
TYPE	Month/Day/Year	TYPE
_____	_____	_____
TYPE	Month/Day/Year	TYPE

Parent/Guardian Signature \_\_\_\_\_  
Home Phone \_\_\_\_\_

Date \_\_\_\_\_  
Work Phone \_\_\_\_\_

Doctor or Clinic Name \_\_\_\_\_

Clinic Phone \_\_\_\_\_