School ____ Grade ______________ School Year ________________

School Health Service
Student Health History

Dear Parent:

We would like your child to gain the most from their school experience. In order for us to assist in accomplishing this, it is necessary to have a health history. Please complete Pages 1 & 2 of this form and return to school.

Section 1. Contact Information

Student's Name ____ Sex ________Birthdate _______________

Address ____ Home Phone: __________________________

Mother's Name ____Cell Phone: ___________________________

Address ____ Home Phone: _________________________

Employer ____Work Phone: ___________________________

Father's Name ____Cell Phone: ___________________________

Address ____ Home Phone: _________________________

Employer ____Work Phone: ___________________________

Guardian's Name ____Cell Phone: ___________________________

Address ____ Home Phone: _________________________

Employer ____Work Phone: ___________________________

With whom does this child live? ____

Section 2. Siblings

Number of brothers: ________ Number of sisters: ________ This child is number ______ in the family.

Name of brother/sister ____ Age ___________

Name of brother/sister ____ Age ___________

Name of brother/sister ____ Age ___________

Section 3. Insurance Information

Name of Insurance ____ TennCare: Yes _____ No _____

Section 4. Physician Information

Name of Physician ____ Office Phone: _________________________

Hospital Preference: ____ City ____________________________

Date of child's last physical exam _____________________ Purpose: Routine checkup _____ Illness/Injury _____

Section 5. Health History

Does your child have any of these health problems?

Allergies/Epi-Pen _____ Seizures/Convulsions _____ Vision ______

Asthma _____ Diabetes/Insulin _____ Hearing ______

Heart _____ Psychological/Behavioral _____ History of Surgery _____

Does your child take medication (including over-the-counter medications)? Yes _____ No _____

If yes, list medication ____________________________________

Dosage (how much) _________________________

How often _______________________

Has this child been hospitalized for any reason since birth? Yes _____ No _____

If yes, why? ____

Does a close relative in your family have a history of: (check and indicate relationship to this child)

Diabetes ____ Asthma __________________________________

Severe Allergies ______________________________________ Seizures __________________________________

Does your child have?

Prescription dietary needs? Yes _____ No _____

Special Equipment? Yes _____ No _____

Activity Limitations? Yes _____ No _____

Safety Precautions: Yes _____ No _____

Is there anything more about this child's health that you think is important for us to know? Yes _____ No _____

Explain:____

____

____

I give permission to share this information with school staff as needed.

Parent's Signature ____

Date ______________________________