Lakeview Local Schools

Student Health History Form

Students Name - Last, First, M.I | **Date of Birth** | **Age** | **Sex** M ☐ F ☐

School | **Teacher (K- Grade 5 Only)** | **Grade** | **Height** | **Weight**

Student Health Conditions – Choose Yes or No – Provide details when answering Yes

Has your child been diagnosed with **ASTHMA** or **REACTIVE AIRWAYS**? If Yes, approximate date of diagnosis? _____	Yes ☐	No ☐
Has your child ever had **WHEEZING, SHORTNESS of BREATH or CHEST TIGHTNESS**? If Yes, what brought on the episode? _____	Yes ☐	No ☐
Is your child **EPILEPTIC** or has s/he ever had a **SEIZURE**? If Yes, what type of seizure? _____ Approximate date of diagnosis? _____ Date of last seizure? _____	Yes ☐	No ☐
Is your child **DIABETIC**? If Yes, approximate date of diagnosis? _____	Yes ☐	No ☐

Student Health Conditions – Check Any That Apply

- ☐ Abnormal spinal curvature (Scoliosis)
- ☐ Anemia
- ☐ Anaphylactic reaction to _____
- ☐ Attention deficit disorder
- ☐ Autisim
- ☐ Birth malformation _____
- ☐ Blood Sugar ☐ High / ☐ Low
- ☐ Cancer (Diagosised: _____) Type: _____
- ☐ Cerebral Palsy
- ☐ Concussion (Date: _____)
- ☐ Constipation, Diarrhea, Irritable Bowel
- ☐ Contacts / Glasses
- ☐ Cystic Fibrosis
- ☐ Ear infections, frequent
- ☐ Emotional problems
- ☐ Eye Problems ☐ Left / ☐ Right
- ☐ Hearing Problems ☐ Left / ☐ Right
- ☐ Heart disease
- ☐ Hemophilia
- ☐ Hepatitis
- ☐ HIV positive
- ☐ Hyperactivity
- ☐ Juvenile arthritis
- ☐ Kidney disease
- ☐ Meningitis or Encephalitis
- ☐ Menstrual cycles have begun
- ☐ Menstrual cramps, severe
- ☐ Migraines (Diagosised: _____)
- ☐ Mutism
- ☐ Nervous tics or twitches
- ☐ Sinus infections/headaches, frequent
- ☐ Skin problems
- ☐ Sore throats, frequent
- ☐ Speech difficulties
- ☐ Thyroid disorder
- ☐ Urinary tract infections, frequent

PreSchool – 5th Grade ONLY

- ☐ Stool Soiling
- ☐ Tourette's syndrome
- ☐ Wetting during day /night

6th Grade – 12th Grade ONLY

- ☐ Acid reflux
- ☐ Alcohol problem suspected / confirmed
- ☐ Behavior problems
- ☐ Blood pressure ☐ High / ☐ Low
- ☐ Body piercing (_____)
- ☐ Drug problem suspected / confirmed
- ☐ Eating disorder suspected / confirmed
- ☐ Knee problem ☐ Left / ☐ Right
- ☐ Mono (Date: _____)
- ☐ Pregnancy
- ☐ Sexually transmitted disease
- ☐ Smokes
- ☐ Sports injury

Any other medical condition(s) not listed:

	Allergy Type	Reaction	School restrictions or recommended actions
☐	Medication		
☐	Food		
☐	Plants /Animals / Insects / Other		

	Prescription or OTC Medicine /Dose	Time	Reason
1.			
2.			

Please list any SEVERE INJURIES, ILLNESSES, and HOSPITALIZATIONS below (including inpatient and outpatient)

Please describe any PHYSICAL LIMITATIONS your child has below

Name of person completing form | **Relationship to Student** | **Daytime Contact #** | **Date**

I give permission to share this information with school personnel for the benefit of my child **Yes** ☐ **No** ☐