HOLLAND PATENT CENTRAL SCHOOL – STUDENT HEALTH HISTORY

Name of Student ______________________________ DOB ____________________

Family Doctor ______________________________ Dr. Phone ________________

HISTORY OF ILLNESS (Please List Dates)

Allergies/ list ____________________________
(Food Allergies need to be documented with a Doctor's signature)

Allergic to Bee Stings____________________
Is an Epipen required? Yes_____ No______

Anemia______________________________

Asthma______________________________

Chicken Pox (the disease)________________
(Must be documented with Dr signature for exemption from vaccine requirement)

Diabetes______________________________

Ear Conditions_________________________

Epilepsy/Seizure Disorder________________

Fractured Bones________________________

Heart Disease/Murmur____________________

Hospitalizations________________________

Medications (list those currently taking)

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Migraines____________________________

Mononucleosis________________________

Urinary Problems______________________

Pneumonia___________________________

Rheumatic Fever______________________

Scarlet Fever_________________________

Skin Conditions_______________________

Surgeries____________________________

Tuberculosis__________________________

Other Serious Illness___________________

Does your child wear glasses?_________ Date of last eye exam_________Next exam due_________

Please include any other information concerning your child's health that you feel school should be aware of:____

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______________________________________ ____________
Parent/Guardian signature *Date*

*** Dear Parent/Guardian: Please complete & return form to Health Office.**