STUDENT HEALTH HISTORY USD #356

Please Print

Student Name_____Date of Birth_____Grade_____

Parent Name_____Phone Number_____

Please circle Yes or No

Yes No **1.** Is your child on medication on a routine basis?
If yes, what?_____

Yes No **2.** Will the medication be given at school? (Requires additional form)

Yes No **3.** Is your child diabetic?

Yes No **4**. Has your child been diagnosed (by a physician) with asthma?
How often does your child use a rescue inhaler?_____

Yes No **5**. Has your child been diagnosed (by a Physician) with ADD or ADHD?

Yes No **6**. Allergies (food allergies require additional form)

Food_____Reaction:_____

Insect bites/stings:_____Reaction:_____

Environmental:_____Reaction:_____

Medications:_____Reaction:_____

Does your child require an Epi-Pen? Yes____No___Which allergy?_____

Yes No **7**. Is your child on a special diet? (Requires additional form)
If yes, what?_____

Yes No **8**. Does your child have limitations or restrictions?
If yes, what?_____

Yes No **9**. Does your child wear glasses?

If yes, for what?_____

List any other vision problems_____

Yes No **10**. Does your child have any ear or hearing problems?
If yes, what?_____

Yes No **11**. Does your child have any other health problems?

If yes, what?_____

This information will be shared with school staff that has contact with your child.

I give consent for information on the Kansas Certificate of Immunization to be released to the Kansas Immunization Program for the purpose of assessment and reporting.

Parent Signature_____Date_____