UNIFIED SCHOOL DISTRICT #480
STUDENT HEALTH HISTORY

STUDENT NAME:_____BIRTHDATE:_____
DATE: _____ GRADE: _____ PHONE: _____

Please check any related illness or condition that your child has currently or has had in the past and explain in "Comments" below.

- My child has no known health problems

- ADD/ADHD: Medication required: ___Yes___No
- Allergy: Insect. Med required:___Yes___No
- Allergy: Food (List)_____
- Allergy to Medication: (list)_____
- Allergy Seasonal (list meds taken) _____
- Anemia
- Asthma: Medication/Inhaler required ___Yes___No
- Autism
- Birth Defect/Chromosome Disorder
- Blood Disorder
- Blood/Blood products not to be given
- Cancer/Leukemia
- Cerebral Palsy
- Color Perception Difficulty (colorblind)
- Cystic Fibrosis
- Diabetic: Insulin Dependent:___Yes___No
- Down's Syndrome
- Ear Infections (frequent)
- Ear Tubes: R__L__Both__ Date:_____
- Eating Disorders
- Emotional/Psychological Disorder
- Endocrine Disorder
- Growth Disorder
- Hearing Loss: R____L____ Both_____
- Hearing Aid used: R____L____Both_____
- Heart Disease/Defect: Restrictions: ___Yes___No
- Hemophilia
- Hospitalizations or Surgeries _____
- Hypoglycemia
- Kidney Disorder
- Medication Prescribed _____
- Medication needed at school ***Requires Medication Permission Form***
- Menstrual Cramps (severe)
- Migraine Headaches: Med required: ____Yes____No
- Muscular Dystrophy
- Nose Bleeds (frequent)
- Orthopedic Condition _____
- Osgood Schlatter Disease
- Physical Activity Limitations ***Requires Doctor's Note***
- Scoliosis
- Seizure Disorder: Med required:___Yes___No
- Sickle Cell Anemia
- Ulcer
- Vision Impairment
- Other _____

COMMENTS:_____

_____

_____

By signing this form you are allowing this information to be shared with teachers/staff as needed.
I ALSO GIVE MY CONSENT FOR IMMUNIZATION INFORMATION TO BE RELEASED TO THE KANSAS IMMUNIZATION PROGRAM FOR PURPOSES OF ASSESSMENT AND REPORTING TO PREVENT DISEASE.

PARENT/GUARDIAN SIGNATURE:_____

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