SHARON CITY SCHOOL DISTRICT
HEALTH HISTORY

To Parents or Guardian: The information requested on this form will be of help to the School Authorities in determining the health status of your child and is assisting him/her to receive maximum benefits from his/her educational opportunity.

Name of Child_____

Address_____

Date of Birth___/___/_____SS#_____Phone_____

Father's Name_____Mother's Name_____
(First) (Last) (First) (Last)

Child lives with_____

Past History of Health- Please check if your child has had any of the following:

☐ Allergies ☐ Frequent colds/sore throat ☐ Pneumonia

☐ Asthma ☐ Strep throat ☐ Rheumatic fever

☐ Bronchitis ☐ Heart disease ☐ Scoliosis

☐ Hernia ☐ Chickenpox (date___/___/____) ☐ Kidney disease

☐ Diabetes ☐ Mononucleosis ☐ Convulsions/seizures

☐ Ear infections ☐ Serious accidents/injuries_____

☐ Tuberculosis ☐ Other serious illnesses_____

Operations/Dates:

☐ Appendectomy (date___/___/_____) ☐ Tubes in ears (date__/___/_____)

☐ Tonsillectomy (date___/___/_____) ☐ Other operations_____

Any severe allergic reaction to insect stings, medications, food or latex?_____

If so, please explain_____

Any medications?_____If so, please list_____

_____

Signature of Parent/Guardian_____Date___/___/_____