EDWARDSVILLE DISTRICT 7 HEALTH SERVICES -- STUDENT HEALTH INFORMATION SHEET

Health History to be completed and signed by parent/guardian

Student's Name: Last	First		Middle
Birth Date (MM/DD/YYYY)	**Sex**	**School**	**Grade**
Address			
City	**State**	**Phone #**	

Allergies (food, drug, dog, insect, other)

Medication (List all prescribed or taken on a regular basis)

Medical and/or Mental health concerns diagnosed by physician

Please respond to each:	**Select**	**Indicate Severity/Explanation**
Diagnosis of asthma?	Yes ☐ No ☐	
*If yes, provide copy of student's asthma action plan		
Child wakes during the night coughing?	Yes ☐ No ☐	
Birth defects?	Yes ☐ No ☐	
Developmental delay?	Yes ☐ No ☐	
Blood disorders? Hemophilia, Sickle Cell, Other? Explain	Yes ☐ No ☐	
Diabetes?	Yes ☐ No ☐	
Head injury/Concussion/Passed out?	Yes ☐ No ☐	
Seizures? What are they like?	Yes ☐ No ☐	
Heart problem/Shortness of breath?	Yes ☐ No ☐	
Heart murmur/High blood pressure?	Yes ☐ No ☐	
Dizziness or chest pain with exercise?	Yes ☐ No ☐	
Bone/Joint problem/injury/scoliosis?	Yes ☐ No ☐	
Loss of function of one of paired organs? (eye/ear/kidney/testicle)	Yes ☐ No ☐	

Student Name:		
Hospitalizations? (Date and Reason)		
Surgery? (List all with dates)		
Please respond to each:	**Select**	**Indicate Severity/Explanation**
Serious injury or illness?	Yes ☐ No ☐	
*TB skin test positive (past/present)?	Yes ☐ No ☐	
*TB disease (past/present)?	Yes ☐ No ☐	
*If yes, refer to local health department.		
Tobacco use (type, frequency)?	Yes ☐ No ☐	
Alcohol/Drug use?	Yes ☐ No ☐	
Family history of sudden death before age 50? (Cause?)	Yes ☐ No ☐	
Vision		
Eye/Vision problems? ☐ Glasses ☐ Contacts	Last exam by eye doctor:	
Other concerns (crossed eye, drooping lids, squinting, difficulty reading)?		
Hearing		
Ear/Hearing problems?	Yes ☐ No ☐	
Dental		
☐ Braces ☐ Bridge ☐ Plate ☐ Other		
Other concerns?		
Information may be shared with appropriate personnel for health and educational purposes.		
Please provide the information requested below for use only in the case of an emergency. When there is an injury and we must take your child to a hospital, hospitals require proof that can provide basic information on your child and that we can show evidence that he/she is covered by insurance.		
The above named student is covered by (insurance co.):		
Policy Number:	**Group Number:**	
Primary Person Insured:		
Parent/Guardian Signature: _____ **Date:**_____		