# *Department of Health*

PRINT

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## SCHOOL HEALTH HISTORY FORM

LUCAS ELEMENTARY SCHOOL Grade _____ Date of birth _____

Student's name _____ Student's physician _____

Exact address _____

Home phone _____

Father or guardian's name _____ Employer _____

Mother's name _____ Employer _____

**MEDICAL HISTORY**

Scarlet Fever _____ Rheumatic Fever _____
Frequent colds/sore throat _____ Frequent ear infections _____

Convulsions/Seizures (explain) _____

Allergies: _____

Serious illnesses in the past _____

Vision: Date of last eye exam: _____ Does your child wear glasses? _____

Does your child have any known vision problems? _____

Hearing: Does your child wear a hearing aid? _____

Does your child have any known hearing problem(s) _____

Speech problem(s) _____ Dental problem(s) _____

Behavior or emotional problems (please explain): _____

_____

Is your child on medication? If so, please specify the name of the drug and what condition it was prescribed for:

Other health problems:

Parent Guardian Date

_____ _____

**DPT, Diphtheria, .Pertussis., Tetanus, Combination**

**DT Diphtheriaand Tetanus Combination**

**MMR - Measles, Mumps. Rubella Combination**

**rev1.0 607**

**HBVHepatitisB**

**HIS-Hemaphilus**