

Student Health History

To be filled out by the Child's Physician

Student's Name _____ Date of Birth _____

Parent's Name _____ Today's Date _____

Address _____ City _____

State _____ Zip _____ Phone _____

Child's Physician _____ Office Phone _____

Office Address _____ City _____

State _____ Zip _____

Has the child been under the regular care of a physician? _____

Date of last physical examination _____

Height _____ Weight _____ Vision needs _____ Dental needs _____

Accidents _____

Operations _____

Allergies _____

Past/Present Illnesses: (Give approximate date of illness)

Chicken Pox _____

Rheumatic fever _____

Mumps _____

Epilepsy _____

Measles (red, hard) _____

Rubella (German measles) _____

Hay fever _____

Mumps _____

Asthma _____

Heart Disease _____

Diabetes _____

Cholera _____

Convulsion _____

Polio Myelitis _____

Kidney Disease _____

Bladder Disease _____

Sinusitis _____

Hepatitis _____

Meningitis _____

Eczema _____

Scarlet fever _____

Whooping cough _____

Diphtheria _____

Small Pox _____

Typhoid fever _____

Pneumonia _____

Other _____

Does the child have any other physical or mental conditions that should be known to school personnel? (Hearing, infections, earaches, digestive problems, Attention Deficit Disorder, etc.)

**Physician's Signature _____ Date _____

Email to: office@happylandprek.com