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Cleveland Heights-University Heights City Schools

Student Health Information Form

For Office Use Only:
SID:_____
School:_____

Student Name_____**Date of Birth**_____**Grade**_____

Physician's Name_____Phone#_____

Dentist's Name_____Phone#_____

PLEASE CHECK ALL THE FOLLOWING THAT THE STUDENT CURRENTLY HAS OR HAS HAD IN THE PAST:

☐ Allergies – List all **Student has an Epi-Pen:** ☐ **Yes** ☐ **No**

Food_____ *Reaction* _____*Recommended Treatment*_____

Insect Stings_____ *Reaction* _____*Recommended Treatment*_____

Plants/Animals _____ *Reaction* _____*Recommended Treatment*_____

Medications _____ *Reaction* _____*Recommended Treatment*_____

☐ Asthma **Student Uses an Inhaler at School:** ☐ **Yes** ☐ **No**

☐ Convulsions/ Seizures *Frequency*_____ *Medication* _____

☐ Diabetes **Student uses Insulin:** ☐ **Yes** ☐ **No** **Student uses oral medication:** ☐ **Yes** ☐ **No**

☐ Attention Deficit Hyperactivity Disorder (ADHD/ADD) *Medication:* _____

☐ Chicken Pox Disease *Date* _____

☐ Ear Infections *Frequency* _____*Age of last infection* _____ *Tubes*_____

☐ Frequent Cold/ Sore Throat

☐ Hearing Problems *Describe* _____*Hearing Aid? Yes*_____ *No* _____

☐ Heart Disease *Describe* _____

☐ Kidney Disease *Describe* _____

☐ Migraines *Treatment* _____

☐ Rheumatic Fever *Date* _____

☐ Sickle Cell Anemia

☐ Skin Disorder *Describe* _____

☐ Speech Problems *Describe* _____

☐ Stomach / Intestinal Disorders *Describe* _____

☐ Strep Infections *Frequency*_____ *Date of last infection* _____

☐ Tuberculosis

☐ Vision Problems *Describe* _____*Treatment* _____

☐ Other Physical Disabilities *Describe*_____

PLEASE ANSWER THE FOLLOWING QUESTIONS:

Does your child take any medications daily? Specify _____ ☐ Yes ☐ No

What medications are given frequently, but not daily? _____

Does your child have any emotional/behavioral health concerns? ☐ Yes ☐ No

Describe _____

Has your child ever had any operations or serious illnesses? ☐ Yes ☐ No

Explain _____

Has your child had any serious accidents? ☐ Yes ☐ No

Explain _____

Does your child wear eyeglasses, contacts, braces, or any other corrective devices? ☐ Yes ☐ No

Describe _____

Is your child able to participate fully in a physical education program? ☐ Yes ☐ No

Parent/Guardian Name (Please Print) _____

PARENT/GUARDIAN SIGNATURE _____**DATE** _____

(pc 1/2012)