HEALTH HISTORY FOR NEW ENROLLEE

STEEL VALLEY SCHOOL DISTICT

SCHOOL _____ GRADE _____

PREVIOUS SCHOOL _____

To Parents or Guardians: The information requested on this form will be of help to the school authorities in determining the health status of your child.

Student's Name _____ Birthdate _____

Address _____ City _____

Name of Parent/Guardian _____ Telephone _____

Name of student's physician or other source of medical Telephone _____

Has your child had any f the following? · If yes, give date and detai!s.

Pneumonia ..... ☐ ☐ _____
Diabetes ..... ☐ ☐ _____
Sickle Cell Disease ..... ☐ ☐ _____
Frequent Sore Throats ..... ☐ ☐ _____
Joint or muscle Pain..... ☐ ☐ _____
Hay Fever ..... ☐ ☐ _____
Allergies..... ☐ ☐ _____
Seizure Disorder..... ☐ ☐ _____
Serious Accidents ..... ☐ ☐ _____
Operations..... ☐ ☐ _____
Behavior Problems..... ☐ ☐ _____
Bone Disease ..... ☐ ☐ _____
Vision Problems-Glasses ..... ☐ ☐ _____
Heart Problem ..... ☐ ☐ _____
Any Chronic or Recurrent
Illness no! listed above ..... ☐ ☐ _____

1. List any medications that your child is taking on a regular schedule _____
2) List any medications your child is allergic to: _____

_____

3) List any health problem or illness you or your child's physician feels should be known to the school personnel _____

4) List any restrictions your child may have: _____

5) Is our child able to participate Physical Education Class? ☐ YES ☐ No