Health History Form 2024/25

Addison Community Schools

This form should be filled out by the child's parent/guardian. Return the completed form to the Health Office.

Student's Name: _____ Date of Birth_____ Gender ____ Teacher _____

Address: _____

PARENT/GUARDIAN INFORMATION

Parent/Guardian #1 Name_____ Email _____

Telephone # (H) _____ © _____ (W)_____

Parent/Guardian #2 Name _____Email _____

Telephone # (H) _____ © _____ (W) _____

Emergency Contacts: Name _____ Relationship _____ Phone # _____

Name _____ Relationship _____ Phone # _____

MEDICAL HISTORY

Health Concerns: Does your child have any health concerns the nurse needs to be aware of? ☐ Yes ☐ No

If YES, please describe: _____

Can your child participate in all school activities? ☐ Yes ☐ No

Allergies: Does your child have any allergies? ☐ Yes ☐ No If YES, what is your child allergic to? _____

Does your child have an Epi Pen? ☐ Yes ☐ No

Asthma: Does your child have asthma? ☐ Yes ☐ No If YES, when was he/she diagnosed? _____

Does your child use a rescue inhaler? ☐ Yes ☐ No

Medication: Does your child currently take medications? ☐ Yes ☐ No If YES, what medication? _____

_____

Past Medical History: Date of last doctor's visit _____ Date of last dental visit _____

Does or has your child received medical care for any of the following: ☐ Asthma ☐ Diabetes

☐ Heart Disease ☐ Kidney Disease ☐ Seizure ☐ Mental Health ☐ Concussion/Head Injury

☐ Orthopedic ☐ Other: _____

☐ Hospitalization(s): _____

_____

MEDICAL PROVIDER INFORMATION

Primary care provider: Name:_____ Phone #:_____

Dentist: Name:_____ Phone #:_____

Other Provider: Name: _____ Phone #:_____

Health Insurance type: ☐ None ☐ Private ☐ Other ☐ Dental

If you do not have a doctor or health insurance: Would you like assistance finding a healthcare provider? ☐ Yes ☐ No

Would you like assistance obtaining health insurance? ☐ Yes ☐ No

Would you like assistance finding a dentist? ☐ Yes ☐ No

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