



STUDENT HEALTH HISTORY

To be completed by parent or guardian at time of enrollment/enrollment confirmation:

Name of Student _____ Grade _____

School _____ Male or Female (circle one) Birth date _____

Physician _____ Phone _____

	Yes	No		Yes	No		Yes	No
ADD/ADHD			DIABETES Type I/ Type II			VISION PROBLEMS contacts / glasses		
ALLERGIES drug / seasonal			ORTHOPEDIC IMPAIRMENT			OTHER		
ALLERGIES food/ insect			EARACHES					
EPI-PEN			FRACTURE					
ANEMIA/ BLEEDING PROBLEMS			HEADACHES migraine / tension			LAST DOCTOR EXAM- YEAR		
ANXIETY/DEPRESSION			HEARING/SPEECH PROBLEMS			LAST DENTIST EXAM-YEAR		
ARTHRITIS			HEART CONDITION			LAST EYE DOCTOR EXAM-YEAR		
ASTHMA mild / moderate / severe			RECENT SURGERY					
BLADDER/BOWEL PROBLEMS			SEIZURES			MEDICATIONS TAKEN REGULARLY:		
CANCER			SINUS PROBLEMS			PURPOSE	DRUG	DOSE
CHICKENPOX			STOMACH PROBLEMS					
CYSTIC FIBROSIS			TONSILLITIS					
DENTAL PROBLEMS			TUBERCULOSIS					

If the answer to any of the above is YES, please explain: _____

Has the student visited the emergency room or hospital for this condition? Please explain: _____

Will your student need to take routine medications at school? **Yes No** (circle one)

Students requiring any medication to be given at school **MUST** have a current school year Medication Request and Release form on file. Physician authorization is required for any prescription medication given at school. Please contact the school or go on-line to <http://www.norman.k12.ok.us/group/parents/forms/medrel.pdf> for medication consent forms.

I give permission for my child to receive non-invasive health screening that may include: hearing, vision, height, weight (including Body Mass Index), temperature, blood pressure, pulse, scoliosis, head and neck, and dental hygiene checks. **Yes No**

Parent/Guardian signature _____ Date _____