DPCA Student Health History

Dear Parent/Guardian,
Information requested on this form is needed to maintain a school health record for your child. Please complete and return this to your child's school.

Students Name (first, last, middle) **Birth Date (Mo. Day Year)** **Sex (M,F)** **Grade**

Student's Physician **Phone#** **Date of last physical exam**

Student's Dentist **Phone#** **Date of last exam**

To the best of your knowledge, does your child have a history of or current problems with the following: (Please check YES or NO. If yes ,please comment.)

Problem	No	Yes	Comments (there is additional space on back for comments.)	Is the problem resolved? Y/N ** If not, what is being done?**
Hospitalization?(When/Why?)				
Surgery? (When/Why?)				
Allergies (food, insects, Pollens, Medications or other)				
Serious Allergic Reaction?				
Asthma				
Behavior or Emotions(ADD, ADHD, OCD or other				
Bleeding (frequent nosebleeds or other)				
Bone/Joint Problem (scoliosis, etc)				
Chicken Pox			Date:	
Concussion or other Head injury			Describe:	
Diabetes (If yes, does child need Insulin injections?)				
Ear Problem (Hearing loss, aides)				
Eye or Vision problem (glasses/contacts)				
Headaches or Migraines				
Heart Problem				
Hepatitis				
Frequent Infections: Ear, Strep Or other)				
Kidney Disease				
Lead Poisoning				
Measles(German,3/10day)or Mumps			Which? Date:	
Meningitis				
Rheumatic Fever/Scarlet Fever			Which? Date:	
Seizures				
Sickle Cell Anemia				
Stomach (ulcers, stomachaches, etc.)				
Limits on Activity or Disability				
Does your child need special attention at school related to a health problem?				
Does your child take medication(s) daily, on an as needed basis or for emergencies?			Name of Medication(s) Time(s) taken	For what condition?
Will any medications need to be taken at school?			If YES, please complete a Permission for Medication form (available at school office or in admission Packet) Which Medications?	

** Please see reverse side for additional comments and *required signature.*

Dc5/07

Additional Comments (from front): ______________________________

Is there any other information that you wish to share that might help school personnel Understand and work with your child or you more effectively?

Permission to give your child non-aspirin: (please circle one): YES NO

Signature of Parent/Guardian **Date**