Confidential Health History Review

Student Name:	Birthdate:	Grade:
Parent/Guardian Name:	Daytime Phone:	
Parent/Guardian Name:	Daytime Phone:	

Health Care Provider:	Phone:	Last Visit:
Dentist:	Phone:	Last Visit:
Psychiatrist:	Phone:	Last Visit:
Counselor/Therapist:	Phone:	Last Visit:

Please describe any existing conditions:
Allergies (e.g.: food, medication, environment)
ADD/ADHD (attention deficit (hyperactivity) disorder)
Mental Health (e.g.: depression, anxiety, OCD, oppositional defiant disorder, bipolar disorder)
Other Health Conditions (e.g.: diabetes, autism, seizures/epilepsy, headaches, Tourette's)
Vision Concerns (past/present) Wears lenses for: Distance Reading Astigmatism Other
Hearing Concerns (past/present) PE Tubes: Yes No Hearing Issues: Yes No
Activity Restrictions (if yes, please explain)

Please list the names of the medications taken at…	
Home	
School	

Recent or Significant Hospitalizations			
Date	**Reason**	**Hospital Name**	**Time Period**

_____ _____

Parent/Guardian Signature Date