LOMEGA PUBLIC SCHOOL
STUDENT HEALTH HISTORY INFORMATION

School Year: _____

(TO BE COMPLETED AND SIGNED BY PARENT/GUARDIAN)

STUDENT'S NAME: **DOB:** **GRADE:**

Parent/Guardian Name: _____ **Phone #** _____

Parent/Guardian Name: _____ **Phone #** _____

Emergency Contact: _____ **Phone #** _____

Physician's Name: _____ **Phone #** _____

DOES YOUR CHILD HAVE or EVER HAD:

	YES	NO
1. **ADD/ADHD**		
2. **ALLERGIC REACTION TO:**		
☐ *Aspirin, Ibuprofen, Acetaminophen, Codeine*		
☐ *Penicillin*		
☐ *Erythromycin*		
☐ *Sulfa*		
☐ *Metals - Nickel, Gold, Silver, Other-*		
☐ *Food Allergy - Explain:*		
☐ *Latex*		
☐ *Other -*		
3. **ARTHRITIS** *Date of Onset:*		
4. **ASTHMA/RESPIRATORY** *Date/Explain:*		
5. **CHICKEN POX** *Date of Onset:*		
6. **COUNSELOR** *Name:*		
7. **DIABETES** *Circle: Type 1 or Type 2*		
8. **DIGESTIVE PROBLEMS** *Date/Explain:*		
9. **HEAD INJURY** *Date/Explain:*		
10. **HEARING PROBLEMS** *Explain:*		
11. **HEART PROBLEMS** *Explain:*		
12. **BLOOD PRESSURE -LOW/HIGH** *Date of Onset:*		
13. **MIGRAINES** *How often:*		
14. **NOSEBLEEDS** *How often:*		
15. **SEIZURES** *Date of Onset:*		
16. **SPEECH PROBLEMS** *Explain:*		
17. **VISION CORRECTIVE LENSES** *Circle: Glasses / Contacts / Lasik*		
18. **VISION PROBLEMS (OTHER)** *Explain:*		

CURRENT MEDICATIONS

NAME	DOSE	PURPOSE

SURGICAL PROCEDURES

Is there any other information the school should be aware of concerning your child?

I request the school to contact me in case of an accident or serious illness. If the school is unable to reach me or designated emergency contact as stated above, I hereby authorize the school to call the physician indicated above. I give permission to transport my child to the hospital if needed.

Signature of Parent/Guardian: _____ **Date:** _____

Signature of School Nurse: _____ **Date:** _____