Student Health History

For ALL Students

STUDENT NAME: _____ Date of Birth: _____

☐Parents ☐Guardian Name_____

Student lives with: (please check one) ☐ Both parents ☐ Mother ☐ Father ☐ Other_____

Drug Allergies: _____

Food Allergies: _____

Environmental Allergies: _____

Medication: Please list all medications, both prescription and non-prescription (including herbs, vitamins) taken on a regular basis.

MEDICATION	DOSAGE	HOW OFTEN	WHY TAKING

Please list any past illness: _____

_____

Please list any past surgeries: _____

_____

Please list any current health or wellness concerns:

_____

_____

_____ _____

Signature of Parent/Guardian **Date**

If changes please complete new form	Date	Parent/Guardian Signature
☐ Reviewed/No changes		
☐ Reviewed/No changes		
☐ Reviewed/No changes		