Indian Springs School District 109
Health History Form
School: ______________________

Student's Name: ___________________________ Birthdate: _____________ Grade: ______

Physician's Name: _____________________ Physician's Phone Number: _________________

If your student has ever had any of the following please check:

- ☐ Allergies – Seasonal/Hay fever
- ☐ Allergies: Life Threatening
- ☐ ADD/ADHD
- ☐ Anemia or other Blood Products
- ☐ Asthma
- ☐ Behavior Concerns
- ☐ Blood Pressure Concerns- High/ Low
- ☐ Cancer
- ☐ Chronic Diarrhea/Constipation
- ☐ Chronic Ear Infections
- ☐ Depression
- ☐ Diabetes
- ☐ Emotional/Psychological Concerns
- ☐ Growth and Development Problems
- ☐ Headaches
- ☐ Hearing Concerns
- ☐ Heart Problems
- ☐ Kidney Problems
- ☐ Learning Concerns
- ☐ Orthopedic Problems
- ☐ Premature or low birth weight
- ☐ Sickle Cell Disease
- ☐ Seizure Disorder
- ☐ Sleep Concerns
- ☐ Toothache/Dental Concern
- ☐ Vision Problems

If you checked any of the above, please explain any answers you checked above – include severity, triggers or medications. Please use the reverse side if necessary

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SPECIAL NOTE: If your child needs to take any medications at school; including emergency medications (inhaler or Epi-pen) then you must have a completed Medication Authorization form of file. You may also be asked to have your physician complete an Emergency Action Plan(s) for your child. These forms are available in your school Heath Office

Parent/Guardian Signature: __________________________________ Date: _______________