FUTURE BILINGUAL SCHOOL FOR SPECIAL NEEDS

HEALTH HISTORY FORM

Student's Name: _____ _____ _____ **Current Grade:** _____
First Middle Last

Student's Date of Birth: _____/_____/_____ **Sex:** _____ **Language Spoken:** _____
Country of Birth: _____
Student's Address: _____
City: _____ **State:** _____ **Zip:** _____
Emergency Contact:
Name of Father: _____ **Name of Mother:** _____
Phone: ____-____-_____ **Phone:** ____-____-_____

Condition	Yes	Comments	Condition	Yes	Comments
Allergies (food, insects, drugs, latex)			Head injury, concussions		
Allergies (seasonal)			Diabetes		
Asthma or breathing problems			Hearing problems or deafness		
Attention-Deficit/Hyperactivity Disorder			Heart problems		
Behavioral problems			Lead poisoning		
Developmental problems			Muscle problems		
Bladder problem			Seizures		
Bleeding problem			Sickle Cell Disease (not trait)		
Bowel problem			Speech problems		
Cerebral Palsy			Spinal injury		
Cystic fibrosis			Surgery		
Dental problems			Vision problems		

Describe any other important health-related information about your child (for example; feeding tube, hospitalizations, oxygen support, hearing aid, dental appliance,
etc.):_____
_____

List all prescription, over-the-counter, and herbal medications your child takes regularly:
_____

Check here if you want to discuss confidential information with the school nurse or other school authority.☐Yes☐ No

Please provide the following information	Phone	Date of Last Appointment
Pediatrician/primary care provider		
Specialist		
Dentist		
Case Worker (if applicable)		