HEMPFIELD AREA SCHOOL DISTRICT
STUDENT HEALTH HISTORY

Student's Name (Last, First, Middle)	Date of Birth	Sex M☐ F☐	
		Grade	Homeroom

To the best of your knowledge, does your child have a history, a need, or a concern with the following:

Health Item	Yes	No	Please Comment
Hospitalizations			
Surgery			
Concussion (Head Injury)			
Fractures			
Lead Poisoning			
Eye or Vision Problems			
Ear or Hearing Problems			
Speech Problems			
Cerebral Palsy			
Meningitis			
Heart Problems/Heart Murmur			
Serious Allergic Reactions (food, insects, medications, etc.)			If yes, what type of reaction & treatment:_____
Behavior or Emotional Problems			
Attention Deficit Disorder			
Asthma			If yes, does your child have/use an inhaler?_____
Sickle Cell Anemia			
Diabetes			
Cancer			
Seizure Disorder			
Bleeding Problem (i.e. hemophilia, nosebleeds)			
Limits on Activity			
Bladder or Urinary Problems			
Currently taking medication			Please give name of medication: _____
Medication needed during school hours/school activities			Please give name of medication: _____
Other health concerns/needs			

_____ _____

Parent's Signature Date