

**Blue Valley USD #384
Health History**

Last Name: _____ First Name: _____ Grade: _____

Family Physician: _____ Phone: _____

Family Dentist: _____ Phone: _____

Is Student under a physician's care at this time? _____ If so, please explain _____

***Does Student have a history or currently dealing with any of the following:
(Please be specific)***

____ ADD/ADHD (diagnosed by Physician: Yes __ No __)
YES NO Required Medication: _____

____ Allergies If YES check below
YES NO Food _____ (requires a doctor's note)
Insect bites/stings _____ REQUIRES EPI-PEN? Yes __ No __
Environmental _____
Animals _____
Medication _____

____ Asthma Required Medication: _____
YES NO

____ Bone/Muscle Conditions _____
YES NO (include fractures and scoliosis)

____ Chicken Pox Disease date: _____ Vaccination Dates _____
YES NO

____ Chronic Ear or Throat Infections _____
YES NO

____ Diabetes Initial diagnosis date: _____ Required Medication: _____
YES NO

____ Emotional Problems Required Medication: _____
YES NO

____ Fainting Has Student ever experienced a sudden loss of consciousness? Yes __ No __
YES NO If YES, please explain _____

____ Frequent Headaches ____ Migraines ____ Required Medication: _____
YES NO

____ Head injuries or Major Accidents of any kind
YES NO If YES, please explain _____

