SEBRING LOCAL SCHOOLS

SCHOOL HEALTH SERVICES

School Health History Record/Update

School Year: _____

Student Name: _____ **Male** _____ **Female** _____

Date of Birth: _____ **Grade:** _____

How does this child's development compare to other children, such as brothers/sisters or playmates?
About the same_____ Delayed_____ Advanced_____

Health Conditions: Please check any that your child has or had

Current	Past		Current	Past		Current	Past	
____	____	Allergies	____	____	Cancer	____	____	Hepatitis
____	____	Anaphylactic reaction	____	____	Chickenpox	____	____	Juvenile Arthritis
____	____	Asthma or wheezing	____	____	Cystic Fibrosis	____	____	Meningitis/Encephalitis
____	____	Attention Deficit	____	____	Diabetes	____	____	Seizures/Epilepsy
____	____	Behavior/Emotional concerns	____	____	Ear problems/poor hearing	____	____	Sore throat (frequent)
____	____	Birth/Congenital malformations	____	____	Eczema/skin conditions	____	____	Speech difficulties
____	____	Blood problems	____	____	Eye problems/poor vision	____	____	Toothaches/dental problems
____	____	Bone/Joint problems	____	____	Headache (frequent)	____	____	Urinary tract infections
____	____	Bowel problems	____	____	Heart Disease	____	____	Wetting during day/night

Current Health: Tell us about any current health conditions or concerns.

_____

_____

_____

Illness, Injuries & Hospitalizations (please explain):

_____

_____

_____

Medical Home: Please provide us with your child's current health care provider's name and contact information.

Healthcare Provider/Physician Name: _____ Phone: _____

Address: _____

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