

**LONG BEACH PUBLIC SCHOOLS
STUDENT HEALTH HISTORY**

Name: _____ Age: _____ Birth date: _____

Address: _____ Phone #: _____

Individual Providing Health History: _____ Date: _____

Does this child have an ongoing health concern? (asthma, diabetes, seizures, allergies, etc.) Yes No

If "yes", please describe/explain: _____

Does your child take any medication regularly at home (including allergy medication and emergency medication ie: epi pen)? Yes No

If "yes", please list: _____

Require medication at school? Yes No

If "yes", please list: _____

Is there a history of any hospitalizations, significant injuries, illness or surgery? Yes No

If "yes", please describe and include date(s): _____

Does your child have any other medical concerns? Yes No

If "yes", please describe: _____

Are there any physical activity restrictions? Yes No

If "yes", please describe: _____

Indicate any special dietary needs/restrictions: _____

List any significant medical concerns in family:

Mother _____ Father _____
 Siblings _____ Grandparents _____
 Other _____

(OVER)

Does your child have any vision problems? Yes No

If "yes", please explain and give doctor's name: _____

Does your child wear glasses? Yes No Doctor's Name _____

When are glasses to be worn? _____ Last Exam Date _____

Does your child have problems with ears or hearing? Yes No Tubes? _____

If "yes", please explain and give dates: _____

Has your child had any of the following?

- | | | | | | |
|----------------|-------|----------|-------|------------------------|-------|
| Chicken Pox | _____ | Asthma | _____ | Convulsions/Seizures | _____ |
| Eczema | _____ | Coughs | _____ | Bleeding Tendencies | _____ |
| German Measles | _____ | Diabetes | _____ | Frequent Sore Throats | _____ |
| Mumps | _____ | Epilepsy | _____ | Urinary Infections | _____ |
| Scarlet Fever | _____ | Diarrhea | _____ | Heart Condition/Murmur | _____ |
| Whooping Cough | _____ | Vomiting | _____ | Trouble Urinating | _____ |
| Liver Disease | _____ | Hives | _____ | Stomach Pain | _____ |
| Strep Throat | _____ | Boils | _____ | Rheumatic Fever | _____ |
| Constipation | _____ | Anemia | _____ | Sickle Cell Anemia | _____ |

If checked, please explain and give dates: _____

Please list any additional concerns or information: _____

Signature: _____ Date: _____