

BOISTFORT SCHOOL DISTRICT
STUDENT HEALTH HISTORY UPDATE

Name:	DOB:	Age:	Gender: <input type="checkbox"/> M <input type="checkbox"/> F
Parent/Guardian: (person completing this form)	Home Phone:	Date:	
	Cell Phone:		

IN THE PAST 5 YEARS, has your child	YES	NO	If Yes, please explain and include date:
Had an ongoing medical condition	<input type="checkbox"/>	<input type="checkbox"/>	
Seen a medical specialist	<input type="checkbox"/>	<input type="checkbox"/>	(whom) _____
Been hospitalized	<input type="checkbox"/>	<input type="checkbox"/>	
Had an surgical procedure	<input type="checkbox"/>	<input type="checkbox"/>	
Had an injury requiring an Emergency Room visit	<input type="checkbox"/>	<input type="checkbox"/>	
Had difficulty breathing or chest pain	<input type="checkbox"/>	<input type="checkbox"/>	
Had a bone/muscle injury	<input type="checkbox"/>	<input type="checkbox"/>	
Passed out, had a concussion or serious head injury	<input type="checkbox"/>	<input type="checkbox"/>	
Had a convulsion/seizure	<input type="checkbox"/>	<input type="checkbox"/>	
Had a vision problem or condition	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> glasses <input type="checkbox"/> contacts
Had a hearing problem or condition	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> hearing aid <input type="checkbox"/> cochlear implant
Worn dental bridge, braces or mouthpiece	<input type="checkbox"/>	<input type="checkbox"/>	
ALLERGIES	YES	NO	If Yes, please specify and include date:
<input type="checkbox"/> food <input type="checkbox"/> environmental <input type="checkbox"/> insect <input type="checkbox"/> medication <input type="checkbox"/> seasonal <input type="checkbox"/> other (specify): _____	<input type="checkbox"/>	<input type="checkbox"/>	REACTION: _____ TREATMENT: _____
LIFE THREATENING ALLERGIES?	<input type="checkbox"/>	<input type="checkbox"/>	
EPI PEN REQUIRED?	<input type="checkbox"/>	<input type="checkbox"/>	

CHECK ALL THAT APPLY TO YOUR CHILD:

- | | | |
|---|--|---|
| <input type="checkbox"/> ADHD | <input type="checkbox"/> Ear Infections | <input type="checkbox"/> Scoliosis |
| <input type="checkbox"/> Allergies | <input type="checkbox"/> GI Conditions (ulcer, reflux, IBS) | <input type="checkbox"/> Single Organ (<input type="checkbox"/> kidney, <input type="checkbox"/> testicle) |
| <input type="checkbox"/> Asthma/trouble breathing | <input type="checkbox"/> Headaches/migraines | <input type="checkbox"/> Skin Condition |
| <input type="checkbox"/> Autism Spectrum Disorder | <input type="checkbox"/> Heart Conditions | <input type="checkbox"/> Speech Condition |
| <input type="checkbox"/> Dental Injuries | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Urinary Condition |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Mental Health Condition (please list) _____ | |

CURRENT MEDICATIONS	YES	NO	Please list name, dose, time(s)
Given at school	<input type="checkbox"/>	<input type="checkbox"/>	
Taken at home	<input type="checkbox"/>	<input type="checkbox"/>	
ASSISTIVE EQUIPMENT	YES	NO	Please check all that apply
During or outside of school	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> crutches <input type="checkbox"/> walker <input type="checkbox"/> wheelchair <input type="checkbox"/> other:
TREATMENTS	YES	NO	
During or outside of school	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> insulin/blood glucose monitoring <input type="checkbox"/> inhaler/nebulizer/peak flow monitoring <input type="checkbox"/> special diet (please explain and request Special Dietary Request form for food service accommodations)

Is there any condition that would prevent your child from participating in physical education or sports? If Yes, note from licensed health care provider is required for physical education.

No Yes: _____

Please list any additional concerns: (use back of sheet if necessary) _____

Parent/Guardian Signature: _____ Date: _____