SHERIDAN PUBLIC SCHOOLS

STUDENT HEALTH HISTORY

Student **LAST NAME** **FIRST NAME** **DATE** **GRADE**

Allergy, specify:

Diabetes (date of onset): **Epilepsy (date of onset):**

Under M.D. treatment? Dr's Name

Asthma: **Yes** **No** **Ear infections** **Yes** **No**

Congenital defects, such as cleft lip, cleft palate etc

Ear tubes **Yes** **No** **Year inserted**

Injuries:

Surgery? **Type** **Date**

Heart Condition, specify:

Other:

Significant Family Health History, diabetes, tuberculosis, etc

Physical restrictions or health problems that may require special seating, bathroom privileges, etc

Special diet or food restrictions:

Current medications **What** **How Often**

Any other information regarding your child's health or well-being, that you feel would be helpful