THE SCHOOL BOARD OF ALACHUA COUNTY, FLORIDA
HEALTH SERVICES
STUDENT HEALTH HISTORY

STUDENT:_____SCHOOL:_____GRADE_____

DATE:_____ SIGNED/RELATIONSHIP: _____

1. Has your child had any significant illnesses? Give age and describe: _____

_____

_____

2. Check ☑ if your child has ever had a problem with any of the following. Please explain (under comments) and give approximate age problem began.

_____ Eyes/Vision	_____ Anemia	_____ Skin Problems
_____ Ears/Hearing	_____ Seizures	_____ Stool Soiling/Wetting
_____ Speech	_____ Allergies (to what?)	_____ Balance Coordination
_____ Growth Rate	_____ Asthma	_____ Heart/Rheumatic Fever
_____ Unusual Fatigue	_____ Meningitis	_____ Frequent Colds/Coughs
_____ Frequent Accidents	_____ Fainting syndrome	_____ Pneumonias

COMMENTS: _____

_____

_____

_____

3. What medical problems does your child have now? Describe: _____

_____

Under Dr.'s care for this? Yes_____ No _____

Name of Doctor: _____

Any significant accidents (broken bones, falls, etc.) _____

_____

Hospitalizations/surgeries? _____

4. Does your child take any medicines? Name of medication(s): _____

For what? _____ How often: _____

5. Is your child physically limited? Describe: _____

6. Has any person living with you had TB? Yes_____ No _____

7. Is there anything about your child's health that worries you? _____

_____

_____

8. When did you child last receive a dental check-up? _____

9. Is your water supply well water _____ or city water _____?

10. Does your child receive supplemental Fluoride? Check which types:

Prescribed vitamins with fluoride? _____ Fluoride mouth rinse? _____

Prescribed fluoride tablets? _____ Fluoride treatments from dentist? _____