

Wooster City Schools
Student Health History
(to be completed by parent/guardian)

This information is for school use only and will not be released to unauthorized persons.

Student's Name: _____ Last First MI	Date of birth: _____
Father's (or guardian) Name: _____	Telephone: _____
Mother's (or guardian) Name: _____	Telephone: _____
Child's Physician: _____	Telephone: _____
Child's Dentist: _____	Telephone: _____

Family Health History: tuberculosis, diabetes, asthma, heart disease,...

Medications: Does your child take any medications on a regular basis? If so, please list and indicate which medications, if any, will be taken during the school day.

Student's Health History: Please include dates whenever possible.

Chickenpox: Yes ____ No ____	Epilepsy: Yes ____ No ____	
Diabetes: Yes ____ No ____	Asthma: Yes ____ No ____	
Allergies: Yes ____ No ____	Heart Condition: Yes ____ No ____	
Specify: _____	Frequent ear infections: Yes ____ No ____	
Diagnosed Attention Deficit Disorder :	Bedwetting: Yes ____ No ____	
Yes ____ No ____	Speech/language concerns: Yes ____ No ____	
Diagnosed Hyperactivity (ADHD):	Other: _____	
Yes ____ No ____		

VISION HISTORY:

Has this child had a comprehensive eye exam? Yes ____ No ____ By whom? _____

Glasses: Yes ____ No ____ When prescribed? _____ By whom? _____

List any special considerations needed: _____

HEARING HISTORY:

Has this child had a comprehensive hearing exam? Yes ____ No ____ By whom? _____

Hearing aid: Yes ____ No ____ When prescribed? _____ By whom? _____

List any special considerations needed: _____

RESTRICTIONS: Please list any that may require special consideration including dietary:

Signature of Parent/Guardian _____ **Date** _____