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: _____ **Date of birth:** _____
Last First MI

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** _____

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