Health Services—Flagstaff Unified School District #1

Name: _____ DOB: _____ ID# _____ ❑Female ❑Male

Student Health History

Please check any conditions present NOW and in the past.

❑ Allergy to: _____
Usual reactions: _____
Medications: _____
❑ Asthma _____
Medications to be taken at school: _____
_____
❑ Nasal/sinus condition _____
❑ Pneumonia in the past _____
❑ Dental problems _____
❑ Heartburn/GERD _____
❑ Ulcers/Colitis/Crohn's _____
❑ Bladder/kidney infections _____
❑ Heart condition _____
❑ Bone or joint problem _____
❑ Juvenile arthritis _____
❑ Back problem/Scoliosis _____
❑ Glasses or contacts _____
❑ Color blindness _____
❑ Other eye conditions _____
❑ Ear infections/tubes in the past _____
❑ Hearing loss—circle: Right Left _____
❑ Speech problem _____
❑ History of chickenpox Year: _____
❑ Other health conditions _____

❑ Diabetes—Circle Type 1 or Type 2
Age diagnosed: _____
❑ Thyroid condition _____
❑ Skin condition _____
❑ Migraines or chronic headaches _____
❑ History of severe head injury _____
❑ Seizure condition (type) _____
Medication: _____
❑ Cerebral Palsy _____
❑ Learning Disability _____
❑ Attention Deficit Disorder _____
Medication: _____
❑ Depression or mental health condition _____
Medication: _____
❑ Underweight Overweight (Circle One)
❑ Bleeding disorders _____
❑ Frequent infections (type) _____
❑ Cancer history _____
❑ Birth or congenital condition _____
❑ Past surgeries (type and year) _____
_____
❑ History of severe illness _____
_____
_____

Please contact the school nurse if you have checked any box.

List any other disability or health condition which may limit activities:

List any medications or supplements taken at home:

Additional comments:

Student's Physician: _____ Student's Dentist: _____

Signature of Parent/Guardian: _____ Date: _____

Home Phone: _____ Cell Phone: _____ Work Phone: _____