USD 385 – Andover Public Schools

STUDENT HEALTH HISTORY

Student's Name:_____ Birthdate:_____ Building:_____
Parent/Guardian Name(s):_____ Grade:_____
1st Contact Phone #:_____ 2nd Contact Phone#:_____ 3rd Contact Phone#:_____
Emergency Contact:_____ Phone #:_____

Physician Information:

Name of Physician:_____
Physician's Phone Number:_____
Hospital Preference:_____
Insurance Provider:_____
Recent Weight:_____ Recent Height:_____

Wears:

Glasses: Yes No
Contacts: Yes No
Hearing Aids: Yes No

Immunizations:

Please provide documentation from Doctor or Health Department of any updates within the last year, including name of provider and dates. Kansas law requires all students have current Immunizations. Failure to comply will result in suspension. ***Legal alternatives need to be filled out annually.***

1. Is your son/daughter allergic to any medications? YES NO If yes, what medication(s)?_____

2. Has your son/daughter ever been diagnosed with a food allergy? YES NO IF yes, what foods:_____

3. Has your son/daughter ever been hospitalized overnight? YES NO If yes, what problem(s):
Age Problem_____

4. Has your son/daughter ever had any serious injuries? YES NO If yes, what injuries:_____

5. Has there been any changes in your son's/daughter's health during the past 12 months? YES NO
If yes, please explain:_____

6. Is your son/daughter taking any medication? If so, please provide name of medicine, dose, time & reason for taking:_____

7. Please circle whether your son/daughter ever had any of the following health problems:

ADD/ADHD
Autism
Aspergers' Syndrome
Asthma
Bladder or Kidney Infections
Life Threatening Allergic Reaction
Blood disorders
Cancer
Cerebral Palsy
Depression
Diabetes
Eating Disorder
Learning Disability
Ear Problems
Emotional Disorder
Elevated Cholesterol
Mental Retardation
Hepatitis (liver disease)
Hypertension/High Blood Pressure
Headaches/Migraines
Low Blood Sugars
Pneumonia
Heart Disease
Scoliosis
Seizures/epilepsy
Stomach Problems
Hearing Problems
Tourette's Syndrome
Tuberculosis
Over weight
Mononucleosis (Mono)
Vision Problems/glasses
Drug/Alcohol Abuse
Use Tobacco
Other:_____

8. With whom does your son/daughter live with most of the time? (circle all that apply)

Both parents same household
Mother Stepmother Sisters (ages)_____
Father Stepfather Brothers (ages)_____
Other adult relative Guardian Other_____

9. In the past year, have there been any changes in your family?

Marriage Loss of job Births
Separation Move to a new neighborhood
Serious Illness Divorce A new school Deaths
Other_____

10. In the past year, has your son/daughter stayed overnight in a homeless shelter, jail or detention center? Yes No If yes, please explain:_____

11. What seems to be the greatest challenge for your son/daughter?_____

I give permission for this health information to be released to appropriate school personnel.
Sign: **Date:**

06/07