Health Services—Flagstaff Unified School District #1

Name: _____ Grade: _____ ID# _____
Date of Birth: _____ ❑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: _____