HEALTH HISTORY FOR NEW ENROLLEES
STEEL VALLEY SCHOOL DISTRICT

School ____________________ Grade __________

Previous School ____________________

To Parents or Guardians: The information requested on this form will be of help to the school authorities in determining the health status of your child.

Student's Name ____________________ Birthdate __ / __ / __

Address ____________________ City __________

Name of Parent/Guardian ____________________ Telephone __________

Name of student's physician or other source of medical care ____________________ Telephone __________

Has your child had any of the following? If yes, give date and details.

	Yes	No	
Chickenpox	☐	☐	
Scarlet Fever	☐	☐	
Rheumatic Fever	☐	☐	
Pneumonia	☐	☐	
Diabetes	☐	☐	
Sickle Cell Disease	☐	☐	
Frequent Sore Throats	☐	☐	
Fainting Spells/Dizziness	☐	☐	
Joint or Muscle Pain	☐	☐	
Asthma	☐	☐	
Allergies	☐	☐	
Hay Fever	☐	☐	
Seizure Disorder	☐	☐	
Urinary Tract Infections	☐	☐	
Ear Infections	☐	☐	
Frequent Nosebleeds	☐	☐	
Serious Accidents	☐	☐	
Operations	☐	☐	
Behavior Problems	☐	☐	
Bone Disease	☐	☐	
Vision Problems - Glasses	☐	☐	
Heart Problem	☐	☐	
Any Chronic or Recurrent illness not listed above	☐	☐	

1) List any medications that your child is taking on a regular schedule: ____________________

2) List any medications your child is allergic to: ____________________

3) List any health problem or illness you or your child's physician feels should be known to the school personnel: ____________________

4) List any restrictions your child may have: ____________________

5) Is your child able to participate in Physical Education Class? Yes ☐ No ☐