Helena Public Schools
... a great place to learn

Health History

Today's Date _____

Name _____ Date of Birth _____
(last) (first) (middle)

School _____ Teacher _____ Grade _____

Physician _____ Dentist _____

Please fill in any information that is applicable. Please use the back side if necessary for additional information.

1) Asthma medications _____ symptoms _____

2) Allergy specify _____ symptoms _____

3) Diabetes insulin/snacks _____ symptoms _____ age of onset _____

4) Seizures medications _____ symptoms _____ age of onset _____

5) ADD/ADHD _____ medications _____

6) Visual problems _____ glasses/contacts _____

7) Hearing problems _____ frequent ear infection _____ hearing aids _____

8) Heart condition _____ specify restrictions _____

9) Congenital/Chronic conditions _____

10) Chicken Pox (date) _____

11) Serious injuries (list) _____

12) Operations (list) _____

_____

13) Other _____

_____

_____

14) Special seating, bathroom privileges, restrictions _____

_____

15) Please list medications your student takes both at home and school. **MEDICATIONS GIVEN AT SCHOOL MUST BE CHECKED INTO THE OFFICE.**

_____

_____

16) Immunizations/shots given recently (example: Hep B, Hep A) _____
To update the immunization form, please provide a copy of the record.

_____ _____
Individual Completing Form Relationship to Student

_____
Home Phone

_____
Work Phone