Windham Academy
Student Health History Form

To be completed by Parent/Guardian

Student Name: _____ DOB: _____ ◯ Male ◯ Female

Section 1: Information

Health Insurance Company: _____

Subscriber:_____ Policy # _____ Group # _____

Primary Care Provider: _____ Phone #: _____

Dentist: _____ Phone #: _____

Section 2: Health History

Does your child have any of the following conditions?

☐ Asthma ☐ Allergies ☐ Hearing Loss/Aids ☐ Glasses/Vision Problems

☐ Diabetes ☐ Ear Tubes ☐ Seizure Disorder ☐ Bleeding Disorder

☐ Stomach/Bowel Problems ☐ Heart Condition ☐ ADD/ADHD

If yes, please explain:

_____

_____

_____

Has your child ever had any of the following?

☐ Chicken Pox ☐ Broken bones ☐ Surgery ☐ Other serious accidents/injuries

If yes, please explain:

_____

_____

_____

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Does your child have any other medical conditions?

_____

_____

_____

Section 3: Medication

Does your child take medication routinely at home? If yes, please list:

_____

_____

_____

Does your child need any medications routinely at school? If yes, please list:

_____

_____

_____

Parent/Guardian Signature: _____ Date:_____