

# 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:

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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?

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### **Section 3: Medication**

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

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

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Parent/Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_