Print

SPARTANBURG DISTRICT FIVE STUDENT HEALTH FORM- Due Feb 21st

All information on this form will be kept strictly confidential

STUDENT NAME _____

FAMILY PHYSICIAN_____PHONE_____

FAMILY DENTIST_____PHONE_____

STUDENT HEALTH HISTORY

FOOD ALLERGIES_____

DRUG ALLERGIES_____

ENVIRONMENTAL/SEASONAL ALLERGIES_____

STUDENT PRESCRIPTION MEDICATION LIST: (List all medications student is currently taking at home and/or school)

MEDICATION_____ DOSE & TIME_____REASON FOR MEDICATION_____

MEDICATION_____ DOSE & TIME_____REASON FOR MEDICATION_____

MEDICATION_____ DOSE & TIME_____REASON FOR MEDICATION_____

RECORD OF ILLNESS, HEALTH PROBLEMS THE STUDENT CURRENTLY HAS OR HAS A HISTORY OF:

ADD/ADHD	☐	Stomach problems/Gastric Reflux	☐	Bladder/Kidney	☐
Arthritis	☐	Frequent Headaches	☐	Bowel/Colon	☐
Autism	☐	Migraines	☐	Vision/Glasses/Contacts	☐
Asthma	☐	Heart Disease	☐	Hearing Aid/Hearing Loss	☐
Diabetes type I, IDDM	☐	Seizures	☐	Mental Health/Emotional Condition	☐
Diabetes type II, NIDDM	☐	Dizziness/Vertigo	☐	Mobility Devices	☐
Hypoglycemia	☐	Skin Disorder	☐	Other	☐

This is permission for treatment by a physician and at a hospital for any medical or surgical EMERGENCY ONLY.

Name of Health Insurance Company_____

Group or Identification Number_____

Any other information you may want to give pertaining to your health history (use back if needed):

_____

SIGN HERE

_____ _____

Signature of Parent/Legal Guardian Date