

THE SCHOOL BOARD OF SARASOTA COUNTY, FLORIDA and FLORIDA DEPARTMENT OF HEALTH IN SARASOTA COUNTY  
 SCHOOL HEALTH SERVICES  
**HEALTH HISTORY 2016-2017**

**Instructions:** Complete this form and return it to the school office.

Student Name \_\_\_\_\_ Student No. \_\_\_\_\_ Phone \_\_\_\_\_  
 DOB \_\_\_\_\_ Sex \_\_\_\_\_ School \_\_\_\_\_ Grade \_\_\_\_\_

Check next to any condition or illness that applies to your child. Note: For medication questions, mark the "yes" box only if child is taking medication <u>now</u> . Use the "Comments" section at the bottom of the page for explanations.		(Office Use Only) Code Number
1	<b>Allergies</b> <input type="checkbox"/> Food _____ <input type="checkbox"/> Medicine _____ <input type="checkbox"/> Ants <input type="checkbox"/> Wasps <input type="checkbox"/> Bee stings <input type="checkbox"/> Environmental allergies List _____ <input type="checkbox"/> Other allergies List _____ <b>Specify reaction to allergy or allergen</b> <input type="checkbox"/> Rash <input type="checkbox"/> Swelling <input type="checkbox"/> Hives <input type="checkbox"/> Breathing problems <input type="checkbox"/> Vomiting <input type="checkbox"/> Diarrhea <input type="checkbox"/> Local Reaction <input type="checkbox"/> Takes medication for any allergies List medication(s) _____ Does child need a special diet? <input type="checkbox"/> Yes <input type="checkbox"/> No (If yes, school requires a prescription from a doctor.)	ALF ALFR ALM ALI ALIR ALE ALO ALOR
2	<input type="checkbox"/> <b>Arthritis</b> Explain _____	ARTH
3	<input type="checkbox"/> <b>Asthma</b> List triggers _____ Diagnosed at age _____ <input type="checkbox"/> Takes medication List medication(s) _____ Under doctor's care now <input type="checkbox"/> Yes <input type="checkbox"/> No	AS ASR
4	<input type="checkbox"/> Other frequent <b>Respiratory Conditions</b> Explain _____	RC
5	<input type="checkbox"/> <b>Attention Deficit/Hyperactivity Disorder (ADD/ADHD)</b> <input type="checkbox"/> Takes medication List medication(s) _____	AD
6	<input type="checkbox"/> <b>Blood Disorder</b> <input type="checkbox"/> <b>Sickle cell anemia disease</b> <input type="checkbox"/> <b>Sickle cell anemia trait</b>	BD BDR SIDR SIAT
7	<input type="checkbox"/> <b>Cancer</b> Explain _____	CA CAR
8	<input type="checkbox"/> <b>Cystic Fibrosis</b> <input type="checkbox"/> Takes medication List medication(s) _____	CF
9	<input type="checkbox"/> <b>Dermatological/Skin Condition</b> Explain _____	DERM
10	<input type="checkbox"/> <b>Developmental Delay</b> Explain _____	DEV D
11	<input type="checkbox"/> <b>Diabetes</b> (high blood sugar) <input type="checkbox"/> <b>Type 1</b> <input type="checkbox"/> <b>Type 2</b> <input type="checkbox"/> <b>Hypoglycemia</b> (low blood sugar)	DB1 DB2 HY
12	<input type="checkbox"/> <b>Eating Disorder</b> Explain _____	EATD
13	<input type="checkbox"/> <b>Endocrine</b> Explain _____	ENDO ENDR
14	<input type="checkbox"/> <b>Gastrointestinal</b> Explain _____	GI BWC BWCR
15	<input type="checkbox"/> <b>Gynecological</b> Explain _____	GYN
16	<input type="checkbox"/> <b>Headaches</b> <input type="checkbox"/> <b>Migraines</b> Under doctor's care for this condition <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Takes medication List medication(s) _____	HEAD MI
17	<input type="checkbox"/> <b>Head injury/Concussion</b> Month/Year _____ Explain _____	HIN HINR
18	<input type="checkbox"/> <b>Hearing Condition</b> <input type="checkbox"/> Uses hearing aid _____	HI
19	<input type="checkbox"/> <b>Heart Condition</b> Explain _____ Under doctor's care for this condition <input type="checkbox"/> Yes <input type="checkbox"/> No <b>Physical restrictions</b> <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, explain _____	HC HCR
20	<input type="checkbox"/> <b>Heat Sensitivity/Heat Exhaustion</b> Explain _____	HEAT
21	<input type="checkbox"/> <b>High Blood Pressure</b> (Hypertension)	HP
22	<input type="checkbox"/> <b>Kidney or Bladder Condition</b> Explain _____	KB
23	<input type="checkbox"/> <b>Muscle/bone/mobility Condition</b> Explain _____ <b>Physical restrictions</b> <input type="checkbox"/> No <input type="checkbox"/> Yes Explain _____ Need a doctor note yearly.	MBM
24	<input type="checkbox"/> <b>Neurological Condition</b> Explain _____	NEUR NURR
25	<input type="checkbox"/> <b>Nosebleeds</b>	BN
26	<input type="checkbox"/> <b>Psychiatric diagnosis</b> _____ <input type="checkbox"/> Takes medication List medication(s) _____	PD
27	<input type="checkbox"/> <b>Seizure Disorder</b> How long ago was the last one? _____ <input type="checkbox"/> Takes medication List medication(s) _____	SEIZ SEZR
28	<input type="checkbox"/> <b>Sinus Condition</b> Explain _____	SINU
29	<input type="checkbox"/> <b>Surgery</b> Explain _____ Date _____	SG
30	<input type="checkbox"/> <b>Vision Condition</b> Explain _____ <input type="checkbox"/> Glasses <input type="checkbox"/> Contacts	VI
31	<input type="checkbox"/> <b>My child does <u>not</u> have any of the listed conditions or illnesses.</b>	
Comments or other health information _____		
<b>Parent/Guardian Name (Print)</b> _____		
<b>Parent/Guardian Signature</b> _____ <b>Date</b> _____		