Valley View Public Schools
Community Unit District No. 365-U

Student Health History

School Year 2019-2020

Student Name: _____ Grade: _____ School: _____

Student ID #: _____ Gende ❑ Male ❑ Female Birth Date: _____

(if you indicate YES for any category, Please Explain)

#	Concern	Yes or No	Explanation & Comments
1.	Allergies	☐ Yes ☐ No	
	* Uses EpiPen	☐ Yes ☐ No	
2.	Asthma	☐ Yes ☐ No	
	* Uses Inhaler	☐ Yes ☐ No	☐ Rarely ☐ Once daily ☐ More than once daily ☐ For sports
	* Uses Inhaler at School	☐ Yes ☐ No	
	* Child wakes during night coughing	☐ Yes ☐ No	
3.	Blood Disorders, Hemophilia, Sickle Cell, Other	☐ Yes ☐ No	
4.	Daily Medications	☐ Yes ☐ No	
	* Names of Medication(s)	At Home	
		At School	
5.	Diabetes	☐ Yes ☐ No	
6.	Ear / Hearing Problems	☐ Yes ☐ No	
7.	Glasses / Contacts / Eye / Vision Problems	☐ Yes ☐ No	Last Eye Exam:
8.	Heart Problems / Shortness of Breath	☐ Yes ☐ No	
9.	Heart murmur / High Blood Pressure	☐ Yes ☐ No	
10.	Dizziness or Chest Pain with Exercise	☐ Yes ☐ No	
11.	Bone / Joint problem / Injury / Scoliosis	☐ Yes ☐ No	
12.	Loss of Function of One of Paired Organs? (eye / ear / kidney / testicle)	☐ Yes ☐ No	List:
13.	Hospitalizations	☐ Yes ☐ No	Age: Reason:
14.	Mental Health Concerns	☐ Yes ☐ No	
15.	Neurological Problems	☐ Yes ☐ No	
16.	Physical Restrictions	☐ Yes ☐ No	
17.	Seizures/What are they like?	☐ Yes ☐ No	
18.	Serious Injuries or Illness	☐ Yes ☐ No	
19.	Surgery	☐ Yes ☐ No	When? What for?
20.	Birth Defects	☐ Yes ☐ No	
21.	Developmental Delay	☐ Yes ☐ No	
22.	Head Injury / Concussion / Passed Out	☐ Yes ☐ No	
23.	Dental work	☐ Yes ☐ No	☐ Braces ☐ Bridge ☐ Plate ☐ Other
24.	Tobacco / Alcohol / Drug Use	☐ Yes ☐ No	Type: Frequency:
25.	TB Disease / Skin Test Positive (past / present)	☐ Yes ☐ No	
26.	ADHD / ADD	☐ Yes ☐ No	
27.	Nose bleeds	☐ Yes ☐ No	

I release this information with the appropriate school and emergency personnel for health and educational purposes.

_____ _____

Parent / Guardian Signature Date