DUBLIN UNIFIED SCHOOL DISTRICT

STUDENT HEALTH HISTORY

Student Name:_____ Birthdate: _____

School: _____Grade Entering: _____Today's Date: _____

The following information is considered confidential and is only for use by the school nurse, health clerk, teachers, principal, or other staff who will be in contact with and responsible for your child during the school day.

Physician: _____Date of last physical: _____

Dentist: _____Date of last exam: _____

Check any of these conditions your child has:

	Condition	Pertinent Information
	Allergy**	To what?
	___Mild ___Severe	Medication/Treatment:
	Asthma**	Triggers?
	___Mild ___Severe	Medication/Treatment:
	ADD / ADHD	Medication/Treatment:
	Bladder/Bowel	
	Blood Disorders	
	Cancer	
	Congenital Disorders	
	Dental	
	Diabetes**	Medication/Treatment:
	Fainting	
	Headaches	
	Hearing Loss	Which ear? Hearing aid?
	Heart	Medication/Restrictions:
	Hypoglycemia	Treatment:
	Muscular/Orthopedic	Describe/Limitations:
	Nose Bleeds	Frequency & Severity:
	Seizure/Epilepsy**	Medication:
	Skin Conditions	
	Social/Emotional/Behavioral	
	Speech	
	Vision	Glasses or Contacts: To be worn: ___All the time ___For Distance ___For Reading
	Other	
	Takes medication daily	Specify:
	Medication at school*	Specify:

**Students receiving any medication at school must have a current, signed "Medication Authorization & Consent Form" on file in the Health Office –Forms available in the school office.*

***Students with severe or chronic conditions should have a current, signed "Action Plan" on file in the Health Office - Forms available in the school office.*

I understand the above information will be shared with school staff members.

Parent/Guardian Signature: _____ Date: _____