AOS 91 Health History Form

Student Information:
Last name_____ First name_____
Nickname, if any_____ Date of Birth_____

Allergies:

Is you child allergic to any of the following? If "yes", please note their **reaction**
Bee Stings/Insect bites **Yes No** _____
Nuts **Yes No** _____
Medication **Yes No** _____
Specific Foods **Yes No** _____
Animals **Yes No** _____
Environmental/Seasonal **Yes No** _____
Are any of these allergies LIFE THREATENING? **Yes No**
If "Yes", which one (s) is life threatening?_____
If "Yes" Does your child have their own Epi-Pen? **Yes No**

Medications:
If your child is currently taking any medication(s), either by prescription or over-the-counter on a regular basis? **YES NO** If "Yes", please indicate medication name and dose._____
_____

Past Medical History:
Has your child ever had any of the following illnesses? Please write in most recent date of occurrence if applicable.

Chicken Pox_____ Measles_____ Mumps_____ Rubella_____
Whooping Cough _____ Pneumonia_____ Ear Infection_____ TB _____
Strep Throat _____

Was your child born Full Term (between 37 and 42 weeks?) **Yes** **No** If "No", please state how many weeks gestation he/she was at birth_____

Did your child need any special care after birth, such as NICU care or was on a ventilator? **Yes** **No** If "Yes", please describe _____

Student Name _____ DOB_____

AOS 91 Health History Form (cont'd)

Current Medical History
Please check any that currently pertain to your child.
Asthma_____ Diabetes _____ Cystic Fibrosis _____ Seizures _____
Heart Disorder_____ Kidney Disorder _____ Nerve Disorder_____
Throat Disorder_____Bone Disorder_____Blood Disorder _____Muscle Disorder_____
High Blood Pressure_____ Fainting_____ Eczema _____ Other _____
If checked, please explain_____
_____
_____
Has your child ever been hospitalized overnight? **Yes No** If "Yes", please give details and date(s)_____
Has your child ever had surgery? **Yes No** If "Yes", please give details and date(s)
_____

Current Concerns: Please check any that apply
Vision_____ Hearing_____ Speech_____ Height/Weight_____ Breathing_____
Headaches_____ Aggression_____ Activity Level_____ Social Skills_____
Bowels_____ Bedwetting_____ Thumb sucking_____ Eating Habits_____
Sleep_____
Any concerns not mentioned above?_____

Family/ Family History:
Are there any current health concerns in your family that may be impacting your child? If "Yes", briefly explain_____
_____
Sibling's Name(s) Sex Date of Birth State of Health
_____
_____
_____
Does anyone in the house smoke cigarettes? **Yes No**
If "Yes", does this person smoke in the home? **Yes No**
Does the child use a bicycle helmet? **Yes No**
Does the family routinely use seat belts in the car? **Yes No**
Do you have working smoke detectors in your home? **Yes No**

Parent/Guardian's Signature_____Date _____