SAN LEANDRO UNIFIED SCHOOL DISTRICT
HEALTH HISTORY FORM

Student Information

Student Name: _____ Birth Date: _____ Grade: _____

School: _____

Parent/Guardian Name(s): _____ Phone: _____

Physician: _____ Phone: _____

Dentist: _____ Phone: _____

Student Health Concerns

Check all that apply.

- ☐ Allergy, Bee Stings/Insect*
- ☐ Allergy, Hay Fever/Environmental*
- ☐ Allergy, Drugs*
- ☐ Allergy, Food*
- ☐ EpiPen
- ☐ Asthma
  - Asthma Inhaler? ☐ Yes ☐ No
- ☐ ADD/ADHD
- ☐ Autism
- ☐ Bleeding/Clotting Disorder
- ☐ Cancer
- ☐ Cerebral Palsy
- ☐ Chronic Ear Infections
- ☐ Cystic Fibrosis
- ☐ Diabetes
- ☐ Eczema/Chronic Skin Condition
- ☐ Frequent Diarrhea or Constipation
- ☐ Frequent Leg/Joint Pain
- ☐ Hearing Impaired
  - Hearing Aids? ☐ Yes ☐ No
- ☐ Heart Condition
- ☐ High Blood Pressure
- ☐ Kidney/Urinary Condition
- ☐ Migraine Headaches
- ☐ Physical Activity Limitations
- ☐ Orthopedic Condition
- ☐ Scoliosis
- ☐ Seizure Disorder/Epilepsy
- ☐ Sickle Cell Disease
- ☐ Thyroid Condition
- ☐ Tires Easily
- ☐ Tourette Syndrome/Tics
- ☐ Vision Impairment
- ☐ Wears Glasses or Contacts
- ☐ Other (List in Comments Below)

***List specific allergies in Additional Comments**

Additional Comments: _____

Medications

Please list any prescription or over the counter medication that your student takes on a regular basis. Medication cannot be dispensed at school without a formal request signed by a doctor and parent/guardian. Medication forms are available in the school office.

Medication and Dose	Time	Reason

Parent/Legal Guardian Signature: _____ Date: _____