Falls Community Health School-Based Student Health History

521 North Main Avenue
Sioux Falls, SD 57104
www.siouxfalls.org

Dear Parent or Guardian:

In order to provide the best health care for your child, we must understand your child's health history. This form requests information which is helpful if heath care services are requested or needed.

Student Name: _____ DOB: _____

Grade: _____ Sex: _____

Does your child now have **or** ever had any of the following? (Check if yes.)

High blood pressure ☐
Heart condition ☐
Asthma ☐
Severe allergies ☐
Diabetes ☐
Serious skin conditions ☐
Rheumatic heart fever ☐
Frequent and severe headaches ☐
Dizziness or fainting ☐
Severe head injury ☐
Scoliosis ☐
Bone or joint problems ☐
Excessive worry ☐
Depression ☐

Ulcer ☐
Chronic abdominal pain ☐
Excessive colds ☐
Speech problems ☐
Eye trouble ☐
Wear glasses ☐
Frequent ear infections ☐
Hearing loss ☐
Intestinal trouble ☐
Epilepsy (convulsions) ☐
ADD or ADHD ☐
(Attention deficit disorder or Attention deficit/Hyperactivity disorder)

Any medical problems, injuries, or behavioral issues that haven't been mentioned above:

_____

Allergies: _____

Is your child currently taking medications? Yes ☐ No ☐

If yes, please list them: _____

_____

_____

Will you be administering the medications to your child? Yes ☐ No ☐

Will you be providing the medications to the school nurse for administration? ? Yes ☐ No ☐

Does your child have a severe bee sting sensitivity? Yes ☐ No ☐

If yes, does your child have emergency medications available if needed? Yes ☐ No ☐

If yes, will you be providing them to the school nurse? Yes ☐ No ☐

Signature of person completing this form: _____ Date: _____

Thank you for providing this information so that we may better care for your child.