Galena Unit School District #120
Student Health History Questionnaire

Student Name:_____ **Birth Date:**_____ **Grade:** _____

Please provide the following information for the purpose of initiating or updating your son or daughter's school health record. **If this information changes during the school year, please notify the nurse.**

Emergency Contact Information

Mother/Guardian: _____ Preferred Phone:_____

Father/Guardian:_____ Preferred Phone:_____

Other Contact:_____ Preferred Phone:_____

Preferred Hospital: _____

Primary Physician: _____

Please indicate which of the following apply to your child and if "yes" please explain on the line provided.

Allergies:

Bees	YES	NO	_____
Reaction to insect bites	YES	NO	_____
Animals	YES	NO	_____
Food	YES	NO	_____
Drugs	YES	NO	_____
Other	YES	NO	_____

Medical Problems:

Asthma	YES	NO	_____
Medical Diagnoses	YES	NO	_____
Birth Defects	YES	NO	_____
ADD/ADHD	YES	NO	_____
Diabetes	YES	NO	_____
Heart Condition	YES	NO	_____
Seizures	YES	NO	_____
Emotional Problems	YES	NO	_____
Surgeries	YES	NO	_____
Hearing Impairment	YES	NO	_____
Vision Impairment/Glasses	YES	NO	_____
Hospitalizations	YES	NO	_____
Special Diet	YES	NO	_____

Please list any medications your child is taking: _____

_____

_____

Please list any other pertinent health information: _____

_____

_____

_____