CRANSTON PUBLIC SCHOOLS HEALTH HISTORY FORM

Revised 1 15

STUDENT'S NAME: *(Please Print)* **SEX:** **DATE OF BIRTH:**

_____ _____ ___ ___/___ ___/___/___

Last Name *First Name* *M.I.* *M* *F* *Month* *Day* *Year*

HOME ADDRESS & TELEPHONE NUMBER:

_____ _____ ___ _____ _____

Address *City* *ST* *Zip Code* *Home Telephone*

SCHOOL: _____ **GRADE:** _____ **ROOM:** _____

MEDICAL DOCTOR/CLINIC: *(Please Print)*

_____ _____

Name *Telephone*

_____ _____ ___ _____

Address *City* *ST* *Zip Code*

DATE OF LAST PHYSICAL EXAMINATION: ___/___/___

Month Day Year

CHILD REQUIRES USE OF THE FOLLOWING:

___*Contact Lenses* ___*Glasses* ___*Hearing Aid* ___*Cochlear Implant* _____*Other*

ALLERGIES: (please check) **FOOD**___ **INSECT**___ **ENVIRONMENTAL**___ **MEDICATION**___

Please list:: _____

If your child takes medicine for allergies or allergic reactions, please explain: _____

MEDICAL HISTORY : *(If your child has any of the following diseases or conditions, please explain)*

Anemia	_____	Headaches/Migraines	_____	Nosebleeds	_____
Asthma	_____	Head Injury/Concussion	_____	Physical Disability	_____
Diabetes	_____	Hearing Problems	_____	Seizures	_____
Ear Tubes	_____	Heart Condition	_____	Speech Problems	_____
Eczema	_____	Kidney Conditions	_____	Stomach/Intestinal Problems	_____
Eye/Vision Problems	_____	Lead Poisoning	_____		

Other _____

Please list and describe any hospitalizations, surgeries, or serious illness or injury: _____

_____

_____

MEDICATIONS: *Please list any medications your child is currently taking.*

_____

_____

_____

_____ _____

Signature Parent/Guardian **Date**