

Student Health Information Grades 9-12

Student's Name: _____ Birth Date: _____ Grade: _____ Today's Date: _____

Please check all past and current health concerns that apply to this student. Provide details below.

<p>Cardiovascular</p> <input type="checkbox"/> Anemia <input type="checkbox"/> Bleeding Disorders <input type="checkbox"/> Heart Condition <input type="checkbox"/> Sickle Cell	<p>Mental/ Behavioral Health</p> <input type="checkbox"/> ADHD <input type="checkbox"/> Anxiety <input type="checkbox"/> Autism (ASD) <input type="checkbox"/> Depression <input type="checkbox"/> Eating Disorder <input type="checkbox"/> Self-harm <input type="checkbox"/> Substance Use <input type="checkbox"/> alcohol <input type="checkbox"/> drugs <input type="checkbox"/> smoking <input type="checkbox"/> vaping <input type="checkbox"/> Suicide Attempt <input type="checkbox"/> Tics <input type="checkbox"/> Trauma History <input type="checkbox"/> Other Mental, Behavioral, Emotional, or Social Concerns	<p>Neurological</p> <input type="checkbox"/> Cerebral Palsy <input type="checkbox"/> Fetal exposure to drugs/alcohol <input type="checkbox"/> Headaches / Migraines <input type="checkbox"/> Head Injury / Concussion <input type="checkbox"/> Seizures <input type="checkbox"/> Shunt / Hydrocephalus <input type="checkbox"/> Spina Bifida	<p>Systemic</p> <input type="checkbox"/> Allergies (list below) <input type="checkbox"/> life-threatening/epi-pen <input type="checkbox"/> Cancer <input type="checkbox"/> Diabetes <input type="checkbox"/> Type 1 <input type="checkbox"/> Type 2 <input type="checkbox"/> Eczema <input type="checkbox"/> Genetic Condition <input type="checkbox"/> Hospitalization (in past year) <input type="checkbox"/> Lead Poisoning <input type="checkbox"/> Medical Device <input type="checkbox"/> Premature birth (<35 weeks) <input type="checkbox"/> Skin Condition <input type="checkbox"/> Sleep Concerns <input type="checkbox"/> Special Diet <input type="checkbox"/> Student Pregnant / Lactating <input type="checkbox"/> Surgical History <input type="checkbox"/> Weight / Growth Concerns <input type="checkbox"/> Other (describe below)
<p>Gastrointestinal/Urinary</p> <input type="checkbox"/> Celiac Disease <input type="checkbox"/> Colostomy <input type="checkbox"/> Constipation <input type="checkbox"/> Crohn's <input type="checkbox"/> Diarrhea <input type="checkbox"/> GERD / Reflux <input type="checkbox"/> G/J Tube <input type="checkbox"/> Irritable Bowel (IBS) <input type="checkbox"/> Kidney Condition <input type="checkbox"/> Nausea, frequent <input type="checkbox"/> Urinary Catheter <input type="checkbox"/> Urinary Tract Infections <input type="checkbox"/> Urostomy <input type="checkbox"/> Vomits easily	<p>Musculoskeletal</p> <input type="checkbox"/> Bone/Joint Condition <input type="checkbox"/> Wheelchair/Mobility Device	<p>Respiratory</p> <input type="checkbox"/> Asthma <input type="checkbox"/> Cystic Fibrosis <input type="checkbox"/> Tracheostomy	<p>Vision/Hearing</p> <input type="checkbox"/> Ear Infections (recurrent) <input type="checkbox"/> Ear/PE Tubes <input type="checkbox"/> Eye Condition <input type="checkbox"/> Wears glasses / contacts <input type="checkbox"/> Hearing Loss <input type="checkbox"/> Hearing aid / implant

Please provide details for EVERY box checked above, and additional information you would like the Health Office to have.

Student is allergic to:	Reaction is:	Medications taken for reaction:
_____	_____	_____
_____	_____	_____

Medications – Please list all medications your student takes.

Health Care Provider/Clinic: _____	Clinic Phone: _____
Parent/Guardian Signature: _____	Date: _____
Relationship to Child: _____	Parent Phone: _____