Klamath Falls City Schools
100% Graduation is Our Expectation!

Student Health History

Name: _____ **DOB:** _____ **Date:** _____ **School:** _____

Has this student had any of the following conditions? Check yes or no.
If yes, explain and specify the date when the student was most recently affected by the condition.

Yes	No	Condition	Explanation/	Date
		Allergy: Name allergen AND describe reaction		
		Life Threatening Allergy* (requires rescue medication)		
		Medication Allergy		
		Food Allergy*		
		Food Intolerance		
		Environmental Allergy*		
		Serious or Chronic Illness		
		Anemia or Blood Disorder		
		Attention/ Behavior Disorder		
		Asthma* or Lung Problem		
		Bone or Joint Disorder		
		Cancer		
		Diabetes*		
		Head, Neck, or Spine Disorder		
		Heart Condition		
		Hepatitis		
		Mental Illness:		
		Skin Disorder (eczema)		
		Seizure Disorder*		
		Tuberculosis		
		Urinary or Kidney problems		
		Other:		
		Other Health Concerns		
		Bedwetting		
		Constipation		
		Difficulty with exercise		
		Frequent Headaches		
		Frequent Stomach Aches		
		Hearing Problems		
		Toileting Issues or Accidents		
		Vision Problems: Contacts/Glasses: yes no	_____ all of the time _____ distance only _____reading only	
		Weight issue (obese or underwt)		

* Condition requires additional paperwork.

Medications: List any medications taken regularly by this student (include prescription and non-prescription)*.

_____

_____

Health Care History:

Has this student had any **surgeries**? If yes, explain on the reverse side of this page.
Has this student been **hospitalized**? If yes, explain on the reverse side of this page.
When was this student's most recent **medical** checkup? _____
Where does s/he usually go for **health care**? _____
When was this student's last **dental** checkup? _____
Where does this student usually go for **dental care**? _____

Parent/Guardian Signature: _____ **Date:** _____

PARENT CONTACT INFORMATION:

Name:

Phone:

CURRENT INSURANCE: ___ NONE ☐ OHP ☐ PRIVATE

NOTES:

Health Packets Given

Asthma _____
Food Allergy _____
Allergy: other _____
Nutrition _____
Medication _____
Seizure _____

Volunteer Initial:

Intake interview by: _____ Reviewed by: _____