Student Health History

School District of Fort Atkinson

Student Name_____ Date_____

Current Health Concerns

☐ Yes ☐ No

If yes, please explain_____

Takes medication on a regular basis

☐ Yes ☐ No

If yes, please list medication(s)_____

Side effects from this medication

☐ Yes ☐ No

If yes, please explain_____

Will be being taking medication at school

☐ Yes ☐ No

An Administering Medication to Students form is required if your child will be taking medication at school. This form can be obtained from your child's school.

Allergies

☐ Yes ☐ No

☐ Food ☐ Bee/Insect ☐ Medication ☐ Seasonal/Environmental ☐ Other_____

Requires emergency medication for allergy

☐ Yes ☐ No

If yes, list medication(s)_____

Wears Glasses ☐ Yes ☐ No

Hearing Aids ☐ Yes ☐ No

Chronic Illness/Condition

☐ Asthma

☐ Diabetes

☐ Ear Infections

☐ Hemophilia

☐ Pneumonia

☐ Seizure

☐ Sinusitis

☐ Strep

☐ Tonsillitis

☐ Urinary/Bowel issues