HONOR RIDGE ACADEMY

A New Outlook. A New Future.

Health History Form

Student's name _____ Date of birth _____

1. Does your child have any special health care needs? _____
2. Has a physician ever advised that your child limit his/her physical activities? _____
3. List any medications your child is taking and the ordering doctor's name and number in case of emergency:

   _____

   _____
4. Is your child allergic to food, animals, or pollen? _____
5. Has your child ever had a head injury or unconsciousness? _____
6. Any recent surgeries? _____
7. Has your child ever had seizures, staring spells, or episodes of confusion or disorientation? _____
8. Has your child ever broken or seriously injured any bones or joints? _____
9. Does your child have asthma, wheezing, shortness of breath, and any medication/treatment for it? _____
10. Has your child ever had palpitations or chest pain? _____
11. Has your child ever had hives, trouble swallowing, breathing or another bad reaction to an insect bite, bee sting or any other substance? _____
12. Has your child ever fainted? _____
13. Does your child become tired easily? _____
14. Dates of last examinations for:

    Physical exam: _____ Dental exam: _____

    Neurological exam: _____ Eye exam: _____

It is recommended that the above examinations be done on a yearly basis.

Parent/guardian

Print Name: _____

Signature: _____ Date: _____