(PLEASE PRINT)

JEFFERSON COUNTY HEALTH DEPARTMENT
1541 ANNEX ROAD JEFFERSON, WI 53549 920-674-7275

HEALTH HISTORY

CHILD'S NAME_____ BIRTHDATE_____

ADDRESS_____ HOME PHONE_____

SCHOOL_____ GRADE_____ EMERG. CONTACT & PHONE_____

FATHER_____ HOME PHONE_____ WORK PHONE_____

MOTHER_____ HOME PHONE_____ WORK PHONE_____

GUARDIAN (if other than parent)_____ HOME PHONE_____ WORK PHONE_____

DOCTOR_____ CITY_____ PHONE_____

DENTIST_____ CITY_____ PHONE_____

Dear Parents & Students: In order to update our school health records and to become aware of any health concerns, we request that you complete this questionnaire. Additional information or comments are also welcome. **Should your child have a medical change during the school year, please notify the school.**

PLEASE INDICATE WHICH OF THE FOLLOWING APPLY TO YOUR CHILD: (IF "YES", PLEASE EXPLAIN)

YES	NO	ALLERGIES*
____	____	*Hayfever_____
____	____	*Reaction to insect bites_____
____	____	*Animal_____
____	____	*Food_____
____	____	*Drug_____
____	____	*Other_____
____	____	ASTHMA_____
____	____	DIABETES_____
____	____	EPILEPSY_____
____	____	STOMACH ULCER_____
____	____	HEART CONDITION_____
____	____	RHEUMATIC FEVER_____
____	____	HEMOPHILIA_____

YES	NO	
____	____	HEPATITIS_____
____	____	BIRTH DEFECTS_____
____	____	ORTHOPEDIC PROBLEMS_____
____	____	EMOTIONAL PROBLEMS_____
____	____	SKIN RASHES_____
____	____	BEDWETTING_____
____	____	HYPERACTIVE_____
____	____	SURGERIES:_____
		_____
____	____	ACCIDENTS_____
____	____	INJURIES_____
____	____	DISEASES & CONDITIONS WHICH MAY AFFECT THEIR EDUCATION_____

ANY RESTRICTIONS IN ACTIVITY? ____YES ____NO COMMENT_____

EYES

YES	YEAR	NO	
_____	_____	_____	WEARS GLASSES
_____	_____	_____	WEARS CONTACTS
_____	_____	_____	ANY VISION LOSS
_____	_____	_____	ANY OTHER EYE PROBLEM
_____	_____	_____	ANY EYE SURGERY

EARS

YES	YEAR	NO	
_____	_____	_____	FREQUENT INFECTIONS
_____	_____	_____	ANY EAR SURGERY
_____	_____	_____	HAS HEARING LOSS
_____	_____	_____	HAS HEARING AID
_____	_____	_____	ANY OTHER EAR PROBLEM
_____	_____	_____	TUBES IN EARS

COMMENTS_____

Pertinent updated health information on your child will be shared with the school he/she is attending. If your child is taking medication in school, a medication form needs to be competed. I give permission to have my child participate in the school vision & hearing screening programs.

_____ _____

PARENT/GUARDIAN SIGNATURE DATE COMPLETED