

Oak Grove Lutheran School Student HEALTH FORM

Name _____ School Year _____
 Grade _____ DOB _____ Sex _____

Student's physician/clinic _____ Phone _____

Student's dentist _____ Phone _____

Does student have medical insurance? YES _____ NO _____

HEALTH HISTORY

[Y=currenty under treatment

N=no history

R=problem in the past but currently resolved]

ADD/ADHD	Y	N	R
Asthma	Y	N	R
Bone/Joint Problems	Y	N	R
Diabetes	Y	N	R
Chronic Ear Infections	Y	N	R
Emotional/Behavioral	Y	N	R
Hearing Loss/Issue	Y	N	R
Chronic Headache/Migraine	Y	N	R

Allergies (if yes, see below)	Y	N	R
Heart Condition	Y	N	R
Seizure Disorder	Y	N	R
Head Injury	Y	N	R
Glasses/Contacs	Y	N	R
Weight Concerns	Y	N	R
Nosebleed (freq or severe)	Y	N	R
Skin Problems (chronic or severe)	Y	N	R

Other concerns which may affect student? _____

ALLERGIES Please list and describe any allergies below. Indicate **mild, moderate, or severe**:

Bee/Wasp Stings
Medicines/Drugs
Food/Plants/other
Pollen/Dust/Hay Fever
Recommended treatment student currently receives, or has received in the past: <i>antihistamines:</i> _____ <i>inhalers:</i> _____ <i>EpiPen:</i> _____ <i>other:</i> _____

INJURIES & ILLNESSES Please list any severe injuries or illnesses in the student's history.

Injury/Illness	Age of Child	Hospitalized?

Please complete emergency contact information on reverse.

