ARROWACADEMY
MARKED WITH PURPOSE

Student Health History

(to be completed annually by a parent/guardian)

Please complete and return to health office on or before the first day of school

Student Name:_____ DOB:_____ Grade:_____

Date of last physical exam:_____

Part I: Health Conditions and Injuries (check all that apply)

Chronic or recurring illness:_____

☐ Asthma	☐ Diabetes	☐ Seizures	☐ ADHD diagnosis
☐ Hypertension	☐ Bleeding Disorder	☐ Lyme Disease	☐ Frequent Nosebleeds
☐ Concussion/Head injury	☐ Eyeglasses/Contact Lenses	☐ Fainting	☐ Special Diet regimen
☐ Frequent Stomach aches	☐ Chronic Headaches/Migraines	☐ Hearing Impairment	☐ Eczema

☐ Other (specify)_____

Since the last health exam, has your child had:

Yes	No	
☐	☐	Serious injury requiring medical attention?
☐	☐	Surgical operation or fracture?
☐	☐	Treatment in the emergency room?

Please explain any "yes" answers to the above questions. Include dates: _____

_____

_____

Part II: Allergies (check all that apply)

☐ Food Allergies (Life-Threatening):_____

☐ Food Sensitivity (Non Life-Threatening):_____

☐ Insect Bites:_____ ☐ Medications:_____

☐ Animals:_____ ☐ Latex

☐ Environmental: _____

☐ Other (specify): _____

a. Does your child currently take medication prescribed by a doctor or over the counter medication on a daily basis? Y/N

_____

b. Does your child take any medication on an as needed basis? (i.e. Epipen, Albuterol Inhaler, etc.) Y/N

_____

***Reminder**: TDaP & Meningococcal vaccines are required prior to the start of school for all students entering 6th grade and age 11.

***Reminder**: All preschool age students under 60 months of age must receive a flu vaccine prior to December 31st.

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