

**Environmental Charter School at Frick Park**

**Student Health History Form**

Please Print or Type

<b>Student Last Name, First Name, MI</b>		<b>Social Security # (last 4 digits)</b>		
<b>Address</b>				
<b>City</b>		<b>State</b>		<b>Zip</b>
<b>Telephone</b>	<b>Cell Phone</b>	<b>Date of Birth</b>	<b>Age</b>	<b>Gender</b> <input type="checkbox"/> Male <input type="checkbox"/> Female

<b>Emergency Contacts</b> Parents/persons to be contacted in case of an emergency. Please list two contacts.		
<b>Name:</b>	<b>Phone:</b>	<b>Cell:</b>
<b>Address:</b>		
<b>Name:</b>	<b>Phone:</b>	<b>Cell:</b>
<b>Address:</b>		

<b>Primary Care Physician:</b>	<b>Name:</b>	<b>Phone:</b>
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<b>Primary Dentist:</b>	<b>Name:</b>	<b>Phone:</b>
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<b>INSURANCE INFORMATION</b>			
<b>Insurance Company Name:</b>			
<b>ID #:</b>		<b>Group #:</b>	
<b>Insured's Name (policyholder/responsible party):</b>	<b>Insured's SS #</b>	<b>Insured's DOB</b>	<b>Relationship to Insured</b>

AS YOUR CHILD HAD?	YES	NO	HAS YOUR CHILD HAD?	YES	NO
Recurrent Headaches			Epilepsy		
Eye Problem			Seizures		
Ear Problem			Dizziness		
Nose Problem			Fainting with exercise		
Throat Problem			Head Injury		
Thyroid Disorder			Concussion		
Heart Murmur			Bone Injuries		
Heart Disease			Joint Injuries		
Heart Palpitations			Stomach Problem		
High Blood Pressure			Intestinal Problem		
Low Blood Pressure			Diabetes		
Anemia			Eating Disorder		
Sickle Cell			ADD		
Bleeding Disorders: Hemophilia/Other			ADHD		
Hepatitis			Surgeries		
Kidney Disorder			Hospitalizations		
Bladder Disorder			Mononucleosis		
Pneumonia			Alcohol Abuse		
Bronchitis			Drug Abuse		
Tuberculosis			Sexual Assault		
Seasonal Allergies/Hay Fever			Victim of Violence		
Asthma			Emotional Problems		

Please explain any yes answers above: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

List any allergies (foods, medications, environmental, latex) that your child is allergic to: \_\_\_\_\_  
 \_\_\_\_\_

List any treatment for allergies (Benadryl, epipen, etc.): \_\_\_\_\_  
 \_\_\_\_\_

List any medication your child is currently taking: \_\_\_\_\_  
 \_\_\_\_\_

Please list other diseases, illnesses, permanent disabilities or concerns: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

Is your child currently being treated by a health care professional? If yes, please explain: \_\_\_\_\_  
 \_\_\_\_\_

Parent/Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_