2018-2019 STEP Academy

Student Health History

Enrollment Document 2
To be completed by parent or guardian

Student Information

Student (LEGAL) Name: _____ Grade: _____ Age: _____

Birthdate: _____ Gender: _____ Parent/Guardian: _____

Health Condition and History

1. Did the mother have any unusual problems or illnesses during pregnancy or birth?

   ☐ No ☐Yes, please explain: _____

2. Has your child ever been hospitalized?

   ☐ No ☐Yes, please explain: _____

3. Has your child ever had a serious injury or illness?

   ☐ No ☐Yes, please explain: _____

4. Does your child have any emotional or behavioral problems that affect learning?

   ☐ No ☐Yes, please explain: _____

5. Are there any significant family history or health problems?

   ☐ No ☐Yes, please explain: _____

6. Does your child have any chronic health conditions or problems? Please check all that apply.

☐ ADHD	☐ Heart Disorder	☐ Hearing Problems	☐ Activity Restrictions
☐ Asthma	☐ Joint Pain	☐ Glasses/Contacts	☐ Growth Differences
☐ Depression	☐ Eating Disorder	☐ Vision Problems	☐ Developmental Differences
☐ Headaches	☐ Seizures	☐ Bladder Problems	☐ Frequent Ear Infections/Tubes
☐ Diabetes	☐ Hearing Aid(s)	☐ Bowel Problems	☐ Social/Mental Health Concerns

☐ Other: _____

Please explain any of the above: _____

Please list any allergies: _____

7. Please list any medications your child is taking

Medication Name	Reason
_____	_____
_____	_____
_____	_____

**If any medication will need to be administered at school, please request a medication permission form from the school office.*

8. When was your child's last complete physical exam? _____

9. Please list anything more you feel we should know about your child's health.

   _____