



Houston County Student Health Record

Health Related Services



STUDENT'S NAME _____ STUDENT'S ID # _____ DOB _____

SCHOOL _____ GRADE _____ DATE _____

PARENT/GUARDIAN _____

ADDRESS _____

HOME PHONE _____ MOTHER'S WORK _____ CELL PHONE _____ PAGER NUMBER _____

FATHER'S WORK _____ CELL PHONE _____ PAGER NUMBER _____

EMERGENCY CONTACT (*Is the person on the pick-up list?*) _____

HOME PHONE _____ WORK PHONE _____ CELL PHONE _____ PAGER NUMBER _____

LIST BROTHERS/SISTERS ATTENDING THE HOUSTON COUNTY SCHOOLS AND WHAT SCHOOLS:

MEDICAL HISTORY: (*CHECK ALL THAT APPLY*)

- | | | |
|--|--|---|
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Convulsions w/Fever | <input type="checkbox"/> Migraines |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Cystic Fibrosis | <input type="checkbox"/> Missing Organs (eye, kidney) |
| <input type="checkbox"/> Bleeding Problems | <input type="checkbox"/> Dental Problems | <input type="checkbox"/> Poor Weight Gain |
| <input type="checkbox"/> Blood Pressure | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Premature Birth |
| <input type="checkbox"/> Bowel/Bladder Problem | <input type="checkbox"/> Fainting Spells/Dizziness | <input type="checkbox"/> Rheumatic Fever |
| <input type="checkbox"/> Breathing Problems | <input type="checkbox"/> Frequent Headaches | <input type="checkbox"/> Seizures |
| <input type="checkbox"/> Broken Bones | <input type="checkbox"/> Frequent Nose Bleeds | <input type="checkbox"/> Speech Difficulty |
| <input type="checkbox"/> Bronchitis | <input type="checkbox"/> Hearing Problems | <input type="checkbox"/> Surgery/Hospitalization |
| <input type="checkbox"/> Chronic/Recurrent Illness | <input type="checkbox"/> Heart Murmurs | <input type="checkbox"/> Vision Problems/Contacts |
| <input type="checkbox"/> Chest Pain | <input type="checkbox"/> Heat Exhaustion | <input type="checkbox"/> Weight Problems |
| | | <input type="checkbox"/> Other |

Please explain any "yes" answers on the back. _____

Does your child have any potentially life threatening condition that is not listed above? _____ If yes, please explain. _____

Describe how the above checked items affect your child at school. _____

Are there any known allergies including medication, food, and environment? _____

What kind of reaction occurs with these allergies? _____

List **all** daily medication including home and school. _____

Current Physician: _____ Family Pediatrician: _____ Specialist: _____

After School Program: _____

After School Daycare: (*Name*) _____

Car Ride: _____

Bus #: _____