THE SCHOOL BOARD OF SARASOTA COUNTY, FLORIDA AND
FLORIDA DEPARTMENT OF HEALTH IN SARASOTA COUNTY SCHOOL HEALTH SERVICES

HEALTH HISTORY 2017-2018

Instructions: Complete this form and return it to the school office.

Student Name _____ Student No. _____ Phone _____

DOB _____ Sex _____ School _____ Grade _____

	Check next to any condition or illness that applies to your child. **Note: For medication questions, mark the "yes" box only if child is taking medication now.** Use the "Comments" section at the bottom of the page for explanations.	(Office Use Only) Code Number
1	**Allergies** ☐ Food _____ ☐ Medicine _____ ☐ Ants ☐ Wasps ☐ Bee stings ☐ Environmental allergies List _____ ☐ Other allergies List _____ **Specify reaction to allergy or allergen** ☐ Rash ☐ Swelling ☐ Hives ☐ Breathing problems ☐ Vomiting ☐ Diarrhea ☐ Local Reaction ☐ **Takes medication for any allergies List medication(s)** _____ Does child need a special diet? ☐ Yes ☐ No (If yes, school requires a prescription from a doctor.)	ALF ALFR ALM ALI ALIR ALE ALO ALOR
2	☐ **Arthritis** Explain	ARTH
3	☐ **Asthma** List triggers _____ Diagnosed at age _____ ☐ Takes medication List medication(s) _____ Under doctor's care now ☐ Yes ☐ No	AS ASR
4	☐ Other frequent **Respiratory Conditions** Explain	RC
5	☐ **Attention Deficit/Hyperactivity Disorder** (ADD/ADHD) ☐ Takes medication List medication(s)	AD
6	☐ **Blood Disorder** ☐ **Sickle cell anemia disease** ☐ **Sickle cell anemia trait**	BD BDR SIDR SIAT
7	☐ **Cancer** Explain	CA CAR
8	☐ **Cystic Fibrosis** ☐ Takes medication List medication(s)	CF
9	☐ **Dermatological/Skin Condition** Explain	DERM
10	☐ **Developmental Delay** Explain	DEVD
11	☐ **Diabetes** (high blood sugar) ☐ **Type 1** ☐ **Type 2** ☐ **Hypoglycemia** (low blood sugar)	DB1 DB2 HY
12	☐ **Eating Disorder** Explain	EATD
13	☐ **Endocrine** Explain	ENDO ENDR
14	☐ **Gastrointestinal** Explain	GI BWC BWCR
15	☐ **Gynecological** Explain	GYN
16	☐ **Headaches** ☐ **Migraines** Under doctor's care for this condition ☐ Yes ☐ No ☐ Takes medication List medication(s)	HEAD MI
17	☐ **Head injury/Concussion** Month/Year Explain	HIN HINR
18	☐ H**earing Condition** ☐ Uses hearing aid	HI
19	☐ **Heart Condition** Explain _____ Under doctor's care for this condition ☐ Yes ☐ No **Physical restrictions** ☐ Yes ☐ No If yes, explain	HC HCR
20	☐ **Heat Sensitivity/Heat Exhaustion** Explain	HEAT
21	☐ **High Blood Pressure** (Hypertension)	HP
22	☐ **Kidney or Bladder Condition** Explain	KB
23	☐ **Muscle/bone/mobility Condition** Explain **Physical restrictions** ☐No ☐ Yes Explain Need a doctor note yearly.	MBM
24	☐ **Neurological Condition** Explain	NEUR NURR
25	☐ **Nosebleeds**	BN
26	☐ **Psychiatric diagnosis** _____ ☐ Takes medication List medication(s)	PD
27	☐ **Seizure Disorder** How long ago was the last one? _____ ☐ Takes medication List medication(s)	SEIZ SEZR
28	☐ **Sinus Condition** Explain	SINU
29	☐ **Surgery** Explain Date	SG
30	☐ **Vision Condition** Explain ☐ Glasses ☐ Contacts	VI
31	☐ **My child does not have any of the listed conditions or illnesses.**	

Comments or other health information _____

_____

Parent/Guardian Name (Print) _____

Parent/Guardian Signature _____ **Date** _____