

# Windham Academy

## Student Health History Form



To be completed by Parent/Guardian

Student Name: \_\_\_\_\_ DOB: \_\_\_\_\_  Male  Female

### **Section 1: Information**

Health Insurance Company: \_\_\_\_\_

Subscriber: \_\_\_\_\_ Policy # \_\_\_\_\_ Group # \_\_\_\_\_

Primary Care Provider: \_\_\_\_\_ Phone #: \_\_\_\_\_

Dentist: \_\_\_\_\_ Phone #: \_\_\_\_\_

### **Section 2: Health History**

Does your child have any of the following conditions?

Asthma  Allergies  Hearing Loss/Aids  Glasses/Vision Problems

Diabetes  Ear Tubes  Seizure Disorder  Bleeding Disorder

Stomach/Bowel Problems  Heart Condition  ADD/ADHD

If yes, please explain:

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Has your child ever had any of the following?

Chicken Pox  Broken bones  Surgery  Other serious accidents/injuries

If yes, please explain:

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Does your child have any other medical conditions?

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### **Section 3: Medication**

Does your child take medication routinely at home? If yes, please list:

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Does your child need any medications routinely at school? If yes, please list:

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