HEALTH HISTORY

Tapestry Charter School, Grades K-5
Health Office

A parent of guardian MUST complete this form. **This is NOT the Physical Exam Form**.

Student Name____

☐ Male ☐ Female Birth Date___________________________ Grade______________________

Parent/Guardian Name____

Address____

Home Phone:____________________ Cell Phone:_____________________ Daytime Work:_________________

Has your child ever had?	NO	YES	If, YES, please indicate treatment.
Allergies/Environmental/ Food (please indicate what allergies)			
Anemia			
Bladder/Kidney Problems			
Fainting Spells			
Ear/Hearing Problems			
Headaches			
Frequent Sore Throat			
Head Injury/Concussion			
Fractures/Dislocations			
Skin Rashes			
Chicken Pox			
Asthma			
Arthritis			
Convulsions/Seizures			
Diabetes/Hypoglycemia (low blood sugar			
Eye/Vision Problems			
Contacts/Glasses			
Frequent Stomach Aches			
Frequent Nose Bleeds			
Back/Neck Problems			
Dental Braces/Bridges/Plates/Implants			
Menstruation			Start date:
Anxiety/Depression/Emotional Problems			
Learning Disability			
Autism/Asperger's syndrome			

Please explain the details of the items marked "YES" ____

____

Please list any illness, hospitalizations, operations, or injuries that have not been listed above: _____________

____

I certify the above information provided has been completed to the best of my ability.

Parent/Guardian Name (PRINTED)____

Parent/Guardian SIGNATURE ____