

2025 - 2026 HEALTH HISTORY

Tapestry Charter School Health Office - Grades K-4

A parent/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 explain
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			

If needed, 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) _____ DATE: _____

Parent/Guardian SIGNATURE _____