

**HEALTH HISTORY**  
(To be completed by parent or guardian)

Dear Parent: Please complete this form and return and return to the school as soon as possible.

Name of Pupil \_\_\_\_\_ Date \_\_\_\_\_

Date of Birth \_\_\_\_\_ Sex: M \_\_\_\_\_ F \_\_\_\_\_ Place of Birth \_\_\_\_\_

Address \_\_\_\_\_ Telephone \_\_\_\_\_  
City, State

Father \_\_\_\_\_ Mother \_\_\_\_\_ School \_\_\_\_\_

SIGNIFICANT HEALTH PROBLEMS	Facts to know in case First Aid Treatment is necessary in cases such as bee sting, allergy, epilepsy, diabetes, ect.
Vision Difficulty	
Wears Glasses	
Hearing Difficulty	
Speech	
Emotional	
Bones or Joints	
Convulsions or Fainting	
Diabetes	
Allergies	
Other	