

**JOHNSTON PUBLIC SCHOOLS
STUDENT HEALTH HISTORY FORM**

Female ___

Student Name _____ Date of Birth _____ Male ___

Child's Physician _____ Physician's Phone _____

Has your child ever had or have any of the following?

	NO	YES	YEAR		NO	YES	YEAR
Chicken Pox				Spina Bifida			
Measles				Cerebral Palsy			
Mumps				Downs Syndrome			
Rubella / German Measles				Cystic Fibrosis			
Pertussis / Whooping Cough				Cancer			
Tuberculosis				Hemophilia			
Pneumonia				Seizure Disorder			
Diabetes				Asthma			
Eczema				Heart Condition			
Any bone or muscle condition				Kidney Disease			
Muscular Dystrophy				Anemia			

Is your child prone to the following?

	NO	YES		NO	YES
Frequent headaches			Tonsillitis		
Fainting			Nose bleeds		
Frequent colds			Frequent urination		
Shortness of breath			Gastro intestinal upset		
Strep throat			Nervous habits		
Ear infections			Dizzy Spells		
Hearing problems			Other, please explain		

If you answered yes to any of the above, please elaborate:

(OVER)

