

Fentress County Schools – Student Health History

Student's Name _____ Male _____ Female _____
 Does student have health insurance? ____ Yes ____ No ____ TN Care ID # _____
 Last School Attended (if different) _____
 Doctor's Name _____ Date of last physical _____
 Dentist's Name _____ Date of last exam _____
 Is student under orthodontist's care? _____ Doctor's Name _____

For the following conditions, please check yes or no as applies to your child and give comments.

	YES	NO	
Allergies	_____	_____	Please list (food, drugs, environment, animals, etc) _____
Bee sting allergy	_____	_____	Describe reaction: _____ Have any of the above allergies required emergency treatment in the past? ____ Which one(s)? _____ Does student have an Epi-pen? _____
Asthma	_____	_____	When diagnosed? _____ What triggers you child's Asthma? _____ Medications used to treat: _____
Diabetes	_____	_____	When diagnosed? _____ Take oral medication or insulin? _____
Epilepsy/seizures	_____	_____	Describe seizure _____ Date of last seizure _____ Medication _____ Doctor treating seizure disorder: _____
Heart condition or High Blood pressure	_____	_____	Describe _____ Mediation(s) _____ Any physical restrictions? _____
Bone/joint problems	_____	_____	Describe _____
ADD or ADHD	_____	_____	Treatment _____
Frequent headaches	_____	_____	Treatment _____
Bowel/bladder incontinence	_____	_____	Comments _____
Blood/bleeding disorder	_____	_____	Describe _____
Skin problems/conditions	_____	_____	Describe _____
Stomach problems	_____	_____	Describe _____
Dental/teeth problems	_____	_____	Describe _____
Physical impairments	_____	_____	Describe _____
Other chronic conditions	_____	_____	List _____

Do any of the following apply to your child?

Eyes: ____glasses ____contacts ____difficulty seeing ____lazy eyes ____crossed eyes
 Ears: ____frequent infections ____tubes ____difficulty hearing ____hearing aid (right, left, both)
 Other: ____nosebleeds ____frequent respiratory infections ____eating disorder
 Previous serious illnesses/injuries _____
 Previous surgeries/operations _____
 Other health information, concerns, or needs _____
 Parent/Guardian Signature _____ Date _____