

EDWARD W. BROOKE CHARTER SCHOOL
Health History Form
To be completed by Parent or Guardian

Student's: Last Name _____ First _____ Middle Initial _____ Date of Birth _____

Home Address _____

#1 Parent/Guardian Name _____ Work # _____ Cell # _____ Home # _____

#2 Parent/Guardian name _____ Work # _____ Cell # _____ Home # _____

Guardian is: Both Parents Father Mother Other _____

The following persons reside locally and are authorized to act for parent in the event of illness/injury:

1. Name: _____ Phone: _____

2. Name: _____ Phone: _____

Name of Doctor: _____ Phone: _____

Name of Dentist _____ Phone: _____

Is your child covered by health insurance: Yes No

Insurance Name & Policy # _____

Hospital where your child should be taken in case of emergency _____

Does your child have:

Allergies to Foods: No Yes List: _____

Allergies to Medication: No Yes List: _____

Other Allergies (bees, pollens, etc): No Yes List: _____

Does your child have an Epipen: No Yes Reason: _____

List medication(s) that your child takes: _____

Has your child had:

Yes	No		Yes	No	
___	___	Asthma	___	___	Blood Disorders
___	___	Diabetes	___	___	Fainting
___	___	Heart/Blood Pressure Problems	___	___	Heat Related Problems
___	___	Seizures	___	___	Fractures/Bone Injuries
___	___	Concussions/Head Injuries	___	___	Muscle Problems
___	___	Migraines	___	___	Scoliosis
___	___	Hearing Problems	___	___	Surgeries/Hospitalizations
___	___	Vision Problems	___	___	Chronic Illness

Does your child wear glasses? Yes No

If yes: full time ___ reading ___ distance ___ other ___ (please check all that apply)

Does your child require preferential seating for a vision/hearing problem? Yes No

Is your child receiving speech therapy? Yes No

Please describe any of the problems checked **YES** in more detail.

Do any family/household members any major health problems? Yes No

Does this student have any special needs that the school health program should be aware of? (For example, is it necessary to limit any activity?)

Parent/Guardian Signature

Date

Dear Parent/Guardian:

There may be times when it will be necessary to share some of this information with the school principal, your child's teacher or other school faculty/staff. If there is any reason you would not want this information shared please contact me. Please note that if your child requires medication (over-the-counter and/or prescription) during school hours you must observe the school's medication administration policy. A copy of the policy and required forms are available at the School Health Office. If your child has asthma, please provide the school with an inhaler, letter from your child's primary care provider and an asthma action plan, if necessary. Thank you for your cooperation. And please feel free to contact me with any of your questions or concerns regarding your child's health and well-being in school.

Sincerely,

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