SCHOOL DISTRICT OF HORICON
HEALTH HISTORY FORM

Parents: In order for your child to register and attend school, this form must be completed, signed and returned to school.

Child's Name: _____ DOB: _____ Male/Female

Child's Address: _____ Phone Number: _____

Parent/Guardian Information

Mother/Guardian: _____ Phone Number: _____

Address: _____ Email Address: _____

Father/Guardian: _____ Phone Number: _____

Address: _____ Email Address: _____

Past Medical History and Illnesses – Indicate any of the following that apply:

- ☐ Rheumatic Fever
- ☐ Heart Murmur
- ☐ High Blood Pressure
- ☐ Heart Disease
- ☐ Tuberculosis
- ☐ Asthma
- ☐ Diabetes
- ☐ Stomach/Intestine Problems
- ☐ Thyroid Problems
- ☐ Fainting
- ☐ Mental Illness
- ☐ Epilepsy
- ☐ Meningitis
- ☐ Amputations
- ☐ Athletic Injuries
- ☐ Back Problems
- ☐ Anemia
- ☐ Major Illness
- ☐ Kidney Disease
- ☐ Frequent Headache/Migraine

Has your child ever been hospitalized? _____ If yes, please describe: _____
Has your child had any surgeries? _____ If yes, please list surgeries: _____
Does your child take prescription medication daily? _____
Medication Name: _____ Dosage: _____
Reason: _____ Frequency: _____
Does your child take over-the-counter medication? _____ Medication: _____
Reason: _____ Frequency: _____
Does your child have any allergies? _____ If yes, please list allergies: _____
Please describe allergic reaction: _____
Does your child use an epinephrine auto-injector? _____
Does your child wear glasses/contacts? _____ Does your child have difficulty hearing? _____

Parent Signature: _____ Date: _____

Questions or concerns can be directed to Sarah Kuhnz, School Nurse, 920-485-4423 ext. 114 or skuhnz@horicon.k12.wi.us

(Revised 1/2018)