Rittman School District New Student Health History

Student's Full Name							
Please indicate those items your child receives regular medical / health care for: NO YES	Student's Full N	Name		Fe Fe	male	Date of Birth /	1
Ashma				lth care	for:		
Bedwetting Chickenpox (Date or age	NO	YES					
Chickenpox (Date or age			Asthma				
Diagnosed Attention Deficit Disorder (ADD) Diagnosed Hyperactivity (ADHD) Epilepsy Frequent ear infections Heart Condition Please be specific Speech / Language concerns Other Please indicate those allergies that effect your child: NO YES Bee / Insect Food Please be specific Medication Please be specific Other ADDITIONAL INFORMATION What medications are given daily? What medications are given frequently, but not daily? Has your child had a comprehensive eye exam? No Yes By Whom Does your child wear glasses? No Yes By Whom Has your child had a comprehensive hearing exam? No Yes By Whom Has your child experienced a reduction in hearing? No Yes Yes This information is for school use only and will not be released to unauthorized persons.			Bedwetting				
Diagnosed Attention Deficit Disorder (ADD) Diagnosed Hyperactivity (ADHD) Epilepsy Frequent ear infections Heart Condition Please be specific Speech / Language concerns Other Bee / Insect Food Please be specific Medication Please be specific Other ADDITIONAL INFORMATION What medications are given daily? What medications are given frequently, but not daily? Has your child had a comprehensive eye exam? No Yes By Whom Does your child wear glasses? No Yes Has your child had a comprehensive hearing exam? No Yes By Whom Has your child had a comprehensive hearing? No Yes Has your child experienced a reduction in hearing? No Yes This information is for school use only and will not be released to unauthorized persons.			Chickenpox (Date or age		_)		
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Epilepsy Frequent ear infections Heart Condition Please be specific Speech / Language concerns Other Please indicate those allergies that effect your child: NO YES Bee / Insect Food Please be specific Medication Please be specific Other ADDITIONAL INFORMATION What medications are given daily? What medications are given daily? Has your child had a comprehensive eye exam? No Yes By Whom Does your child wear glasses? No Yes By Whom Has your child had a comprehensive hearing exam? No Yes By Whom Has your child experienced a reduction in hearing? No Yes Yes This information is for school use only and will not be released to unauthorized persons.			Diagnosed Attention Deficit Disorder (ADD)				
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Heart Condition Please be specific Speech / Language concerns Other			Epilepsy				
Speech / Language concerns			Frequent ear infections				
Other			Heart Condition Please be specific				
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NO YES Bee / Insect Food Please be specific Other ADDITIONAL INFORMATION What medications are given daily? What medications are given frequently, but not daily? Has your child had a comprehensive eye exam? No Yes By Whom Does your child wear glasses? No Yes By Whom Has your child had a comprehensive hearing exam? No Yes By Whom Has your child had a comprehensive hearing exam? No Yes By Whom Has your child experienced a reduction in hearing? No Yes Yes This information is for school use only and will not be released to unauthorized persons.			Other				
Bee / Insect Food Please be specific Medication Please be specific Other ADDITIONAL INFORMATION What medications are given daily? What medications are given frequently, but not daily? Has your child had a comprehensive eye exam?			ies that effect your child:				
Food Please be specific Medication Please be specific Other ADDITIONAL INFORMATION What medications are given daily? What medications are given frequently, but not daily? Has your child had a comprehensive eye exam? No Yes By Whom Does your child wear glasses? No Yes By Whom Has your child had a comprehensive hearing exam? No Yes By Whom Has your child experienced a reduction in hearing? No Yes Yes This information is for school use only and will not be released to unauthorized persons.	_	_	Pag / Ingagt				
Medication Please be specific	<u> </u>						
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Does your child wear glasses?	What medication	ons are given	requently, but not daily?				
Does your child wear glasses?	Has your child	had a compre	hensive eve evam? No D	Voc R	Ry Whom		
Has your child had a comprehensive hearing exam?	•	•	•		,		
Has your child experienced a reduction in hearing?	Does your child	wear glasses?	□ N0 □	res			
Has your child experienced a reduction in hearing?	Has your child	had a compre	hensive hearing exam?	Yes B	y Whom	1	
	Has your child e	experienced a re	duction in hearing?	Yes			
Signature of Legal Parent / Guardian Date completed	This informati	on is for sch	ool use only and will not be released to ur	nauthori	zed pers	ons.	
	Signature of	f Legal Parent	/ Guardian		Date comp	oleted	