Rittman School District
New Student Health History

Student's Full Name	Sex ☐ Male ☐ Female	Date of Birth / /

Student's Health Conditions

Please indicate those items your child receives regular medical / health care for:

NO	YES	
☐	☐	Asthma
☐	☐	Bedwetting
☐	☐	Chickenpox (Date or age _____)
☐	☐	Diabetes
☐	☐	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**

Has your child had a comprehensive hearing exam? ☐ **No** ☐ **Yes** **By Whom** _____

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.

Signature of Legal Parent / Guardian	Date completed