UNIVERSITY OF LOUISVILLE
EARLY LEARNING CAMPUS

FOR STAFF USE ONLY

School Year **2017-18**

Classroom _____

Student Health History

Child's Name: _____ **Birth Date:** _____

Does your child have any of the following conditions? (Check correct answer)

Condition	Yes	No	Condition	Yes	No	Condition	Yes	No
ADD/ADHD	☐	☐	Cystic Fibrosis	☐	☐	Sinus Problems	☐	☐
Allergies **Seasonal/Drug**	☐	☐	Dental Problems	☐	☐	Vision Problems	☐	☐
Allergies **Food/Insect**	☐	☐	Diabetes **Type I/Type II**	☐	☐	Other: (Please Specify)		
- Epi-Pen	☐	☐	Orthopedic Impairment	☐	☐			
Anemia/Bleeding Problems	☐	☐	Earaches	☐	☐	**Medications Taken Regularly:**		
Anxiety/Depression	☐	☐	Headaches/Migraines	☐	☐	Purpose	Drug	Dose
Arthritis	☐	☐	Hearing/Speech Problems	☐	☐			
Asthma **Mild/Mod/Sev**	☐	☐	Heart Condition	☐	☐			
Bladder/Bowel Problems	☐	☐	Recent Surgery	☐	☐			
Cancer	☐	☐	Seizures	☐	☐			

• For Immunization Record, see attachment •

If the answer to any of the above is YES, please explain:

_____

_____

Has the student visited the emergency room or hospital for this condition? Please explain:

_____

_____

Will your student need to take routine medications at school? **Yes** ☐ **No** ☐

Has your child been or is your child currently involved in First Steps? **Yes** ☐ **No** ☐

Has your child been or is your child currently involved in any kind of intervention therapy? **Yes** ☐ **No** ☐

If yes, what type of services? (Check all that apply): **Occupational Therapy** ☐ **Physical Therapy** ☐

Speech-Language Pathology ☐ **Developmental services** ☐ **Other**_____

Does your child have an Individual Family Service Plan (IFSP) or Individualized Education Plan (IEP)? **Yes** ☐ **No** ☐

_____ _____

Signature of Parent or Guardian **Date**

_____ _____

Signature of Physician

Date

_____ _____

Office Address Phone Number

Please attach any additional instructions regarding child's special healthcare needs