



Lower School Student Health History Checklist

Grades SK-5

Student's name _____ DOB _____ Grade _____

The answers to these questions will help us know if your child has any medical problems. We are required to have this information in the event that your child should become ill, and we are unable to reach you right away. Please circle the correct response or give the requested information.

Pregnancy and Birth

Yes No Were there any significant problems during pregnancy or your child's birth and newborn period?

If yes, please specify _____

Medical Problems

Yes No Does your child take medicine regularly?

If yes, please specify _____

Yes No Does your child have asthma or wheezing episodes?

Yes No Does your child have speech, hearing, or vision problems?

If yes, please specify _____

Yes No Does your child have frequent tonsillitis?

Yes No Does your child have recurrent bladder or kidney problems?

Yes No Does your child have seizures or fainting episodes?

Yes No Is your child under a physician's care for heart problems?

Yes No Has your child ever had a positive TB skin test?

Yes No Has your child recently been with anyone having TB?

Yes No Does your child have hemophilia or other bleeding problems?

Yes No Does your child have tubes in his/her ears?

Yes No Does your child have any other significant allergy problems?

If yes, please specify _____

Older Girls

Yes No Has your daughter begun having her period?

Yes No Does she have any problems with her period?

General Development

Yes No Does your child get along with other children?

Yes No Does your child have any special problems not indicated above?

If yes, please specify _____

I give permission for Harding Academy to post information regarding any allergies, health alerts, and/or food restrictions pertaining to my child in the classroom and office.

Parent/Guardian's Signature _____ Date _____