CHAMPLAIN VALLEY EDUCATIONAL SERVICES
K – AGE 21 HEALTH HISTORY

SPECIAL EDUCATION DIVISION
(Please complete in blue or black ink)

Student Name: _____ Date of Birth: _____

Please complete all information below. Please be as specific as possible with dates, surgery, etc.

Accidents: _____ Head injury: _____
Loss of consciousness: _____ Fractures: _____
Musculoskeletal/Orthopedic Problems: _____
Limitation of movement: _____ Joint pain or swelling: _____
Braces or Corrective shoes: _____ Scoliosis: _____
Glasses or Contact Lenses: _____ Other eye problems: _____
Hearing loss: _____ Speech Defect: _____
Congenital Heart Disease: _____
Heart Murmur: _____ Rapid heartbeat/Palpitations: _____
Asthma: _____ Cystic Fibrosis: _____
Tuberculosis or TB contact: _____ Diabetes: _____
Skin Problems: _____
Hepatitis: _____ Kidney Disease: _____
Hernia: _____ Undescended or One Testicle: _____
Hospitalizations: (List date and why hospitalized): _____
Operations: _____
Seizures: Yes or No If Yes Please describe: _____
Date of last seizure: _____ Staring Spells: _____

ALLERGIES (Please list and describe reaction):
FOOD: _____ BEE STINGS: _____
HAY FEVER/ENVIRONMENTAL: _____
DRUG/MEDICATION: _____
OTHER: _____

MEDICATIONS (PLEASE LIST NAME, DOSAGE, TIMES YOUR CHILD TAKES):
1) _____ 2) _____
3) _____ 4) _____
5) _____ 6) _____

Date of last complete physical exam: _____ Please provide the Health Office with a copy.
Physician: _____ Phone #: _____
Dentist: _____ Date last seen: _____
Is your child having any dental problems? Yes or No Describe: _____
Has your child seen an eye doctor? Yes or No Name of eye doctor: _____
Date of last visit: _____ Glasses or Contacts prescribed?: _____

Specialist Physician: _____ Phone #: _____

Any other health related information?
_____
_____

PARENT/GUARDIAN SIGNATURE: _____ DATE: _____