#232-N
Student Support Services
928-527-6140
Flagstaff Unified School District, 3285 East Sparrow Avenue, Flagstaff, AZ 86004

FLAGSTAFF UNIFIED School District

Health Services

Student Name: ______________________________ Grade: __________ ID# ____________________

Date of Birth: __________________________ ☐ Female ☐ Male

Student Health History

Please check any conditions present NOW and in the past.

- ☐ Allergy to: ________________________________
  - Usual reactions: __________________________
  - Medications: ____________________________
- ☐ Asthma ________________________________
  - Medications to be taken at school: __________
  - ______________________________________
- ☐ Nasal/Sinus Condition ____________________
- ☐ Pneumonia in the Past ____________________
- ☐ Dental Problems _________________________
- ☐ Heartburn/GERD _________________________
- ☐ Ulcers/Colitis/Crohn's ___________________
- ☐ Bladder/Kidney Infections ________________
- ☐ Heart Condition _________________________
- ☐ Bone or Joint Problem ____________________
- ☐ Juvenile Arthritis _______________________
- ☐ Back Problem/Scoliosis ___________________
- ☐ Glasses or Contacts ______________________
- ☐ Color Blindness
- ☐ Other Eye Conditions _____________________
- ☐ Ear Infections/Tube in the Past ____________
- ☐ Hearing Loss ☐ Right ☐ Left __________
- ☐ Speech Problem ________________________
- ☐ History of Chickenpox Year: _____________
- ☐ Other Health Conditions ___________________

- ☐ Diabetes ☐ Type 1 or ☐ Type 2
  - Age diagnosed: _______________
- ☐ Thyroid Condition ___________________________
- ☐ Skin Condition ______________________________
- ☐ Migraines or Chronic Headaches ________________
- ☐ History of Severe Head Injury _________________
- ☐ Seizure Condition (Type) _____________________
  - Medication: ___________________________
- ☐ Cerebral Palsy _____________________________
- ☐ Learning Disability __________________________
- ☐ Attention Deficit Disorder ____________________
  - Medication: ___________________________
- ☐ Depression or Mental Health Condition __________
  - Medication: ___________________________
- ☐ Underweight ☐ Overweight
- ☐ Bleeding Disorders __________________________
- ☐ Bleeding Disorders __________________________
- ☐ Cancer History _____________________________
- ☐ Birth or Congenital Condition _________________
- ☐ Past Surgeries (Type & Year) _________________
  - ______________________________________
- ☐ History of Severe Illness _____________________
  - ______________________________________

Please Contact the School Nurse if you Have Checked any Box

List any Other Disability or Health Condition Which May Limit Activities: ______________________

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List any Medications or Supplements taken at Home: ______________________________

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Additional Comment: ____

Student's Physician: ______________________ Student's Dentist: ______________________

Parent/Guardian Signature: ___________________ Date: ____________________________

Home Phone: __________________ Cell Phone: __________________ Work Phone: __________