POCONO MOUNTAIN SCHOOL DISTRICT

STUDENT HEALTH HISTORY

Child's Name: _____ Grade: ____ Birthdate: _____

1. List any **MEDICAL CONDITIONS** your child has:

   _____

   _____

   _____

2. List all **MEDICATIONS** that your child is currently taking:
   Daily_____
   As needed_____
3. List any **ALLERGIES** your child has. (Food, insect, medications, other)

   _____

   _____

   Type of reaction_____
4. Does your child have any **PHYSICAL LIMITATIONS**?
   Please list_____
5. Does your child use/wear:
   a. Glasses/contacts Yes_____ No_____
   b. Hearing aid Yes_____ No_____
6. Has your child had the **CHICKENPOX DISEASE**?
   If yes, date of disease_____

Parent/Guardian signature_____Date_____