

Cranston Public Schools
HEALTH HISTORY

Name _____ M _____ F _____ DOB _____
Address _____ Phone _____
School _____ Grade _____ Room _____
Physician Name _____

Last Physical Examination _____
Date _____

Chicken Pox _____ / _____
(Disease) (Immunization)

Current Health Problems: (Check and explain, include treatment(s))

Allergies _____
Anemia _____
Asthma _____
Birth Defect _____
Diabetes _____
Hearing _____
Heart _____
Lead Poisoning _____
Physical Disability _____
Seizures _____
Speech _____
Vision _____
Other _____

My child requires the use of the following assistive devices:

_____ contact lenses
_____ glasses
_____ hearing aid
_____ other

Does your child take any medication? Yes _____ No _____

Medication _____
Dose _____
Frequency _____

List any hospitalizations or major illnesses your child has had.

Additional Information _____

Parent Signature

Date