

PARENT FORM - JFDS / WSCS
HEALTH HISTORY UPDATE AND PARENT CONSENT
(TO BE FILLED OUT BY PARENT/GUARDIAN)

Student's Name: _____ Grade: _____

Age: _____ Date of Birth: _____ Sex: _____

Home Address _____ Home Phone: _____

EMERGENCY CONTACT: _____ Phone: _____

Has/Is your child: (Please circle yes or no)

- | | |
|--|--------|
| 1. Ever had an illness last more than a week? | Yes No |
| 2. Under a physician's care now? | Yes/No |
| 3. Taking any medications? | Yes/No |
| 4. Ever had injuries requiring medical attention? | Yes/No |
| 5. Ever had a surgical operation? | Yes/No |
| 6. Ever stayed overnight in a hospital? | Yes/No |
| 7. Allergic to any medication, foods, insect bites, or other Substances? | Yes/No |

Please explain any "Yes" answers:

Does your child wear contact lenses? Yes/No

Has your child seen a dentist in the past 6 months? Yes/No

Most recent Tetanus Toxoid immunization: Date _____

Was this a booster? Yes/No

Has your child or anyone in the immediate family had: (Please check if yes)

_____ Asthma _____ Convulsions or Epilepsy

_____ Diabetes _____ Migraine Headaches

_____ High Blood Pressure _____ Kidney or Bladder trouble

_____ Heart Murmur _____ Hernia

_____ Rheumatic Fever _____ Tendency to bruise/Bleed easily

Please explain any checks for above conditions:

Parent/Guardian Signature _____ Date _____