MORAGA SCHOOL DISTRICT

HEALTH INFORMATION

Student's Name: _____ Birthdate: _____ Male ☐ Female ☐

Assessment of Student's Health

To the best of your knowledge, has your child had any problem with the following? Please check yes or no.

Condition	Yes	No	Comments, if "Yes", indicate issue & list medications
Allergies – food	☐	☐	
Allergies – drugs	☐	☐	
Allergies – insects	☐	☐	
Allergies – seasonal	☐	☐	
Allergies – other	☐	☐	
Asthma or breathing problems	☐	☐	
Attention-Deficit/Hyperactivity Disorder	☐	☐	
Behavior problems	☐	☐	
Developmental problems	☐	☐	
Bladder problems	☐	☐	
Bleeding problems	☐	☐	
Bowel problems	☐	☐	
Cerebral Palsy	☐	☐	
Cystic Fibrosis	☐	☐	
Dental problems	☐	☐	
Diabetes	☐	☐	
Head or spinal injury	☐	☐	
Hearing problems or deafness	☐	☐	
Heart problems	☐	☐	
Hospitalizations (when, why)	☐	☐	
Lead poisoning	☐	☐	
Muscular problems	☐	☐	
Seizures	☐	☐	
Sickle Cell Disease (not trait)	☐	☐	
Speech problems	☐	☐	
Surgery	☐	☐	
Vision problems	☐	☐	
Other:	☐	☐	

List all prescription and over-the-counter medications your child takes regularly: _____

_____

Describe any other important health-related information about your child (i.e. feeding tube, oxygen support, hearing aid, etc.): _____

_____

Student's Physician _____
Doctor's Name Area Code-Phone Number

Student's Dentist _____
Dentist's Name Area Code-Phone Number

Check here if you want to discuss confidential information with school personnel: Yes ☐ No ☐