SANTA CRUZ VALLEY UNIFIED SCHOOL DISTRICT #35

Student Health Record

Student's Name: _____ Age: _____ D.O.B.: _____

Address: _____Phone: _____

Father's Name: _____ Occupation: _____

(Legal Guardian)

Mother's Name: _____ Occupation: _____

(Legal Guardian)

Family Doctor: _____Phone: _____

Specialist:_____Phone: _____

STUDENT'S MEDICAL HISTORY

No	Yes	Name of disease or illness:	Comments:
☐	☐	ADHD	_____
☐	☐	Allergy	_____
☐	☐	Asthma	
☐	☐	Bleeding Disorder	_____
☐	☐	Seizure Disorders	_____
☐	☐	Activity restrictions/ assistive devices used	_____
☐	☐	Respiratory Conditions	_____
☐	☐	Chicken Pox Date: _____	_____
☐	☐	Diabetes	_____
☐	☐	Eye, Ear, or Nose Conditions	_____
☐	☐	Heart Condition	_____
☐	☐	Measles	_____
☐	☐	German measles	_____
☐	☐	Mumps	_____
☐	☐	Migraine/Headache	_____
☐	☐	Neurologic Disorder	_____
☐	☐	Rheumatic Fever	_____
☐	☐	Strep Infection or Scarlet Fever	_____
☐	☐	Tonsillitis	_____
☐	☐	Whooping Cough	_____
☐	☐	Serious Injury, Accident or Disease	_____
☐	☐	Wears Glasses or Hearing Aid	_____

Previous surgeries: _____ **Date:** _____

Other: _____ **Date:** _____

Where there any complications with this pregnancy? ☐**No** ☐**Yes** **Details:** _____

Medications: _____

Skin Tests Completed to date:	Positive/Negative	Date:
Tuberculin Skin Test	_____/_____	_____
Chest X-Ray	_____/_____	_____
Prophylaxis	_____/_____	_____

Parent or Guardian's Signature: _____Date: _____

*** IF YOUR CHILD NEEDS TO TAKE MEDICATION DURING SCHOOL HOURS, PLEASE PICK UP A REQUEST FORM AT YOUR CHILD'S SCHOOL HEALTH OFFICE FOR YOUR DOCTOR TO FILL OUT AND SIGN.**

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FOR OFFICIAL USE ONLY:

School Site: _____ Grade: _____ Student ID: _____ Enter Date:_____

☐**New student** ☐**Returning student** ☐**Health file at previous district school**