TOWNSHIP OF FRANKLIN PUBLIC SCHOOLS
STUDENT HEALTH HISTORY

Child's Name_____ Birth Date_____ Grade_____

Parent(s)/Guardian(s) Names(s)_____

Home Phone_____ Cell Phone_____ Work Phone_____

Please Note: The following information will be shared with your child's teacher.

Please indicate if your child currently has or has ever had any of the following:	**YES**	**NO**	**YEAR (if known)**
Measles			
Mumps			
German Measles			
Whooping Cough			
Chicken Pox			
Scarlet Fever (tina)			
Strep Throat			
Ear Infections			
Polio			
Pneumonia			
Hepatitis			
Epilepsy			
Diabetes			
Asthma			
Meningitis			

Does your child have any of these allergies:

To medications? _____Yes _____No

If Yes, list here_____

_____

To food? _____Yes _____No

If Yes, list here_____

_____

To bee sting? _____Yes _____No

____Never been stung

If Yes, what medication is given_____

_____

Seasonal? _____Yes _____No

If Yes, what medication is given_____

_____

1) Has your child been hospitalized for any reason? ____No ____Yes If Yes, please explain:_____

_____

2) Does your child take medication on a regular basis? (For allergy, asthma, etc.) ____No ____Yes If Yes, please list what type:_____

3) Does your child have any emotional problem which might affect his/her behavior in school? ____No ____Yes If Yes, please explain:_____

4) Is there any other health information that we have not asked for but you feel would be helpful to us? ____No ____Yes

If Yes, please explain_____

Parent/Guardian Signature:_____ Date:_____