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:_____