PASADENA UNIFIED SCHOOL DISTRICT
HEALTH PROGRAMS

HEALTH HISTORY FORM (to be filled out by parent or guardian)

SECTION 1: STUDENT INFORMATION

Child's Name: ______________ Grade: ______________

Gender: Female ☐ Male ☐ Non-binary ☐

Birthdate: ______________

Phone: ______________ Alternative Phone: ______________

Address: ______________

Parent/Guardian Name: ______________

Emergency Contact Name: ______________

Relationship to student: ______________ Phone: ______________

SECTION 2: PAST MEDICAL HISTORY AND ILLNESSES

If your student is returning to PUSD and has not experienced any changes in their health conditions, proceed to SECTION 3.

Mark with an X any health conditions that the student has had.

	YES		YES		YES		YES		YES
No health problems		Depression		Bladder/Kidney problems		Frequent Colds		Anemia	
Vision problems		Rheumatic Fever		Orthopedic problems		Wheezing		Polio	
Hearing problems		Rubella (3 day)		Frequent headaches/Migraines		Hemophilia		Mumps	
Cancer		Whooping Cough		Frequent Ear Infection		Meningitis		Sickle Cell	
Heart Condition		Tuberculosis		Frequent Sore Throats		Alcoholism		Epilepsy	
Autism		Scarlet Fever		Mental Health diagnosis		Smoking		Anxiety	
Diabetes		Pnuemonia		High Blood Pressure		Substance Abuse		Seizures	
ADHD		Diphtheria		Mononucleosis		Asthma		Other:	

If you checked other, please explain: ______________

Does your student have seasonal allergies and/or allergies to medicine, bee stings and/or food? ______________

If yes, please list allergies. ______________

If your student had a reaction, please describe the reaction to the substance: ______________

Does your student take daily medication? If yes, please list route, dose, and frequency.

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Does your student require any specialized health-related procedures? If yes, please explain.

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SECTION 3: FAMILY HISTORY

If your student is returning to PUSD and there are no changes in the family history of health conditions, proceed to SECTION 4.

Mark with an X the conditions that any family members have had.

	YES		YES		YES		YES		YES
Diabetes		Jaundice		Rheumatic Fever		Alcoholism		Anxiety	
Epilepsy		Syphilis		Bleeding Disorder		Smoking		Depression	
Cancer		Tuberculosis		Hypertension		Anemia		Obesity	
Heart Disease		Substance Abuse		Birth Defects		Kidney Disease		Other:	
Asthma		Allergies							

If you checked other, please explain: ______________

SECTION 4: VISION HEALTH

Please check one of the following:

Student wears glasses for distance.	☐	Student wears glasses for near and distance vision.			☐
Student wears glasses for work up close.	☐	Not sure if student needs glasses.	☐	Other:	☐
No glasses needed by student.	☐	Date of last formal vision exam:	______________		

SECTION 5: INSURANCE

Does your student have health insurance? Please check one of the following:

Private Insurance ☐ Medi-Cal ☐ No Insurance ☐

Please state the name and phone number of your student's current health care provider (primary doctor):

Physician Name: ______________ Phone: ______________ Date of last physical exam: ______________

Anything else you would like the school nurse to know? ______________

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