INTERVAL HEALTH HISTORY

Child's Name_____Grade_____Date_____
Can your child participate in full school activities?_____

Does your child have allergies? Yes No Prescribed Epi-Pen? Yes No
Check all that apply: □Food □Animals □Medicine □Dust □ □Pollen □ □ Insects □ □Other
List specific item(s) student is allergic to_____
_____
Describe allergic reaction and treatment_____
_____

Has your child had any problems with: (check all that apply and describe)

□Asthma
□ADD or ADHD (diagnosed)
□Anxiety
□Bleeding Disorder
□Concussion (Please note number of times)
□Depression
□Dizziness/Fainting
□Diarrhea/constipation
□Eating Disorder
□Headaches/migraine
□Heart Problem
□Hypoglycemia/Diabetes
□ □Kidney problems/urinary frequency
□Lyme Disease
□ □Mood disorder
□ □Persistent coughing or wheezing
□ □Painful joints
□ □Physical limitations
□ □Scoliosis
□Seizure Disorder
□ □Stomach aches/vomiting
□ □Strep throat
□ □ Tires easily
□ □Tonsils/adenoids

Describe above_____
_____
_____
If so, is this condition(s) under the care or observation of a doctor? Yes □ No □
Doctor's name and address:_____

Current Medication(s) Yes □ No □ Please list below.

Name	Dose	Time	Purpose

Has your child had any: (please specify)

□ □Serious injuries
□ □Accidents
□ □Hospitalization
□ □Serious illness (other than above)

Describe_____
_____
_____

Does your child have any eye problems? Yes □ No □ □Contacts □
Describe_____
Does your child have any ear or hearing problems? Yes □ No □ □Hearing Aid(s) □
Describe_____

May we share necessary information above with pertinent staff? Yes □ No □

Revised 1/16