**HEALTH HISTORY QUESTIONNAIRE**

Riverbank Charter School Of Excellence
HOME ★ SCHOOL ★ COMMUNITY

**Student's Name** _____ **D.O.B.** _____ **Grade** _____

Allergies or allergic reactions including eczema or anaphylaxis: (please explain)

_____

Is the student under a physician's care? _____ If yes, for what condition?

_____

_____

Is there any history of asthma/wheezing/reactive airway disease? _____ If yes, please explain.

_____

Is there any history of major injury, concussion, surgery, hospitalization? If yes, please explain.

_____

Does your child have any restrictions, limitations? _____ If yes, please explain.

_____

_____

Please list **all** medications your child is currently taking. _____

How many hours of sleep per night does your child average?_____ Any unusual sleeping patterns or problems? _____

Does your child have any special dietary needs, food allergies, restrictions?

_____

_____

Does your child wear glasses? _____ Does your child have a hearing problem?_____

**Parent/Guardian signature** _____ **Date** _____