Health Record

Child's Name: _____ Birth Date:_____

Please complete the following section:

Condition	Yes/ No	Comments
Allergies (food, insects, medication, environmental allergens)		
Asthma or breathing problems		
Hearing problems		
Vision problems		
Uses contacts or glasses		
Speech problems		
Seizure/ epilepsy		
Bleeding problem		
Cancer/Leukemia		
Diabetes		
Heart problems		
Hospitalizations		
Surgery		
ADD/ADHD		
Other (specify)_____		
Other (specify)_____		
Other (specify)_____		
□Yes □No This student may participate fully in the school program, including physical education and competitive sports. If no, please list restrictions: _____ _____		

Date:_____/_____/ _____

Parent/Guardian: Name_____Signature _____