SCHOOL DISTRICT OF SUPERIOR
Superior, Wisconsin

Student Annual Health History

Date: _____ Students name: _____ Birth date: _____

Parent/Guardian: _____ Phone: _____ Student=s school: _____

Address: _____

Grade: _____ Teacher: _____ M: _____ F: _____

Physician: _____ Dentist: _____

Hospital Preference: _____St. Mary's Superior _____St. Mary's Duluth _____St. Luke's

Allergies: _____ Height: _____ Weight: _____

Does your child have a health problem? Yes _____ No _____
If yes, please explain: _____

_____

Will your child take medication at school? Yes _____ No _____ Reason: _____
If yes, please list:
Medication: _____ Dosage: _____ Time: _____

Medication: _____ Dosage: _____ Time: _____

Does your child take medication at home? Yes _____ No _____ If yes please list _____

_____

All medication must be registered/taken in the health office. If you have medication, please talk to the school nurse.
A permission slip from the parent/guardian must be in place for your child to receive any medication.

Has your child had a surgery, injury or hospitalization? Yes _____ No _____
If yes, please explain: _____

_____

Does your child have any physical education limitations? Yes _____ No _____
If yes, please bring in an excuse from your doctor to the Health Office.

Does your child wear glasses? Yes _____ No _____ Contacts? Yes _____ No ___

Has your child received any immunizations (shots) recently? Yes _____ No _____
If yes, please list kind and date:

DTP/DtaP/DT/Td	Polio	MMR	Hepatitis B	Varicella
1st Dose:	1st Dose:	1st Dose:	1st Dose:	1st Dose:
2nd Dose:	2nd Dose:	2nd Dose:	2nd Dose:	2nd Dose:
3rd Dose:	3rd Dose:		3rd Dose:	
4th Dose:	4th Dose:	**Tdap**		
5th Dose:		1st Dose:		

Remarks or additional information: _____

_____

_____

_____

Your immediate cooperation is much appredicated.

Replaces Student Annual Health History (Rev. 5/02)