Raphael Health Center

Health History Form: Medical Information

Student's Full Name: _____ **Sex:** M ☐ F ☐

Grade:_____ **Date Of Birth:** ___/___/___ **Race:**_____ **Doctor:**_____

Student Address:_____ **Apt #:**_____

City:_____ **State:**_____ **Zip code:**_____

Current Medications*: _____

_____

Raphael Health Center's School Based Clinic at Shortridge High School has over the counter medications stocked (i.e., Tylenol®; Ibuprofen, Hydrocortisone cream, etc.) that may be available to your child depending on his/her symptoms. If you **DO NOT wish Raphael Health Center to provide your child any over the counter medications please initial:_____*

Health Concerns	Yes	No	Health Concerns	Yes	No	Health Concerns	Yes	No
Allergies-seasonal			Diabetes			Painful Periods		
Asthma			Fainting			Seizures		
Bed Wetting			Headaches or Migraines			Sickle Cell Anemia		
Birth Defects			Hearing (hearing aids/devices)			Skin Disorders		
Bladder Infections			Heart Disease			Vision (glasses or contacts)		
EpiPen®			Heart Murmur			Blood Disorder		
Cancer/Leukemia			Kidney Disease			Other (specify):		

Please explain areas above marked "yes":_____

_____

Does your student experience any of the following mental health conditions?

	Yes	No		Yes	No	Other (specify):
ADHD			Eating Disorder			
Autism			Depression			

Hospitalizations/Surgeries:_____

Other important Health Information:_____

Contact Names and Numbers:

Parent/Guardian:	Phone #:
Parent/Guardian:	Phone #:
Emergency Contact:	Phone #:
Hospital Preference:	
Parent/Guardian Signature (required):	