LAKE OF THE WOODS
School

PO Box 310 • 236 15th Ave. SW • Baudette, MN 56623
218-634-2510 • Fax: 218-634-2750
Jeff Nelson, Superintendent
Mary Merchant, School Principal

STUDENT HEALTH HISTORY

Name:_________________________________Male____Female____
Date of Birth:____________________________Grade:___________
Address:____ Parent/Guardian:

Male:______________________________Work Phone:______________
Cell Phone:_______________
Release to: (circle one) Yes No Home Phone:______________

Female:_____________________________Work Phone:_____________
Cell Phone:_______________
Release to: (circle one) Yes No Home Phone:______________

Emergency Contact:________________________Phone:_____________
Release to: (circle one) Yes No
Physician:_______________________________ Phone:_____________
Dentist:_________________________________Phone:_____________

Allergies. Please list the items that your child is allergic to.
_____Food allergy to____
_____Drug or medication allergy to ______________________________
_____Severe reaction to insect stings.____________________________
_____Other allergies. Please list specific type of allergy. _____________
____

Hospitalizations:
Has your child ever been hospitalized?_____
If yes, for what and at what age?_________________________________
____
____
____

(OVER PLEASE)

Medications:
Is your child on any medication on a regular or long-term basis?__________
If yes, please specify:____
____

Illnesses (Please check all illnesses that your child has had.)

_____Asthma
_____Chicken Pox
_____Cystic Fibrosis
_____Eczema
_____Epilepsy
_____Frequent headaches
_____Draining ears
_____Heart trouble
_____Scarlet fever
_____Tonsillitis
_____Whooping cough
_____Bone or muscle trouble
_____Urinary trouble
_____Hayfever
_____Frequent colds
_____Cancer
_____ADHD or_____ADD
_____Diabetes Age of onset_____
_____Earaches
_____Kidney infections
_____Heart murmur
_____Rheumatic fever
_____Tuberculosis
_____Muscular dystrophy
_____Broken bones
_____Hearing trouble _____Hearing aid _____PE tubes in ears
_____Eye trouble _____Glasses _____Contacts

Please describe all illnesses checked above: ________________________
____
____
____
____
____
____