



# HANNIBAL CENTRAL SCHOOL HEALTH HISTORY UPDATE

Student Name: \_\_\_\_\_ Date: \_\_\_\_\_

Grade: \_\_\_\_\_ DOB: \_\_\_\_\_ Home Phone: \_\_\_\_\_

Mother's Name: \_\_\_\_\_ Cell/Work Phone: \_\_\_\_\_

Father's Name: \_\_\_\_\_ Cell/Work Phone: \_\_\_\_\_

Please list below the names of two people who are prepared to assume responsibility of your child in the event of an illness or injury, if we are unable to reach you at your home/cell/work numbers:

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_ Phone: \_\_\_\_\_

Does your child wear glasses? Yes  No

If yes, when? At all times  For reading/board work only

Does your child have hearing problems? Yes  No

Does your child require preferential seating? Yes  No

Is your child allergic to anything?

(i.e. Latex, Band-Aids, Food, Insects, Nuts, Medication, other) Yes  No

If yes, PLEASE SPECIFY ALLERGY: \_\_\_\_\_

ALLERGIC REACTION: \_\_\_\_\_ TREATMENT: \_\_\_\_\_

Call 911? Yes  No

Please list any illnesses/injuries that occurred during the past year: \_\_\_\_\_

\_\_\_\_\_

Is your child taking any medication? Yes  No

If yes, name of medication: \_\_\_\_\_ Dosage: \_\_\_\_\_

Reason for taking medication: \_\_\_\_\_

Any medical problem or concern you want us to know about such as Cardiac, Respiratory or Gastric:

\_\_\_\_\_

Is a specialist treating your child? \_\_\_\_\_

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***I understand the above information will be shared on a need to know basis with my child's teachers, coaches and support staff.***

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**Parent/Guardian Signature**

**Date**