



Health History Form

Student's Full Name: _____ **DOB:** _____

Emergency Contact: _____

Physician's Name: _____ **Phone Number:** _____

Please list any medications your son/daughter is now taking and reason for medication:

Has your student had any of the following:

	Yes	No
1. History of heart problems?	_____	_____
2. High blood pressure?	_____	_____
3. Asthma?	_____	_____
4. Surgery within the last six months?	_____	_____
5. A chronic illness?	_____	_____
6. History of lung problems?	_____	_____
7. Diabetes?	_____	_____
8. Allergic to any foods?	_____	_____

Note: if the answer to any questions above is "Yes," please provide complete details:

In order for ELII to accommodate specific needs during our dining program, please list any foods that your child may be allergic. _____

I hereby certify that the information above is true, correct and complete.

Parent or Guardian's Name (please print)

Signature

Date: _____