Chico School: _____

Grade: _____

CHICO UNIFIED SCHOOL DISTRICT
1163 East Seventh Street
Chico, California 95928
(530) 891-3000

HEALTH HISTORY

Name of Pupil_____ _____ _____ _____
Sex Date of Birth Place of Birth

Pupil's Address_____ Telephone_____

Father's Name_____ Where employed?_____

Mother's Name_____ Where employed?_____

Guardian's Name_____ Where employed?_____

Number of children living at home_____ Child lives with: Both parents___ Father___ Mother___ Guardian___

Yes	No	Head	Age
		Concussion	
		Tendency to faint	
		Convulsions	
		Recurrent headaches	

Yes	No	Eye
		Uncorrectable vision
		One eye, Rt. Lt.
		Color visions defect
		Glasses
		Contact lenses

Yes	No	Ear, Nose, Throat, Mouth
		Hearing Loss
		Chronic ear problems
		Dental appliances
		Difficulty with speech

Yes	No	Special Needs
		Epilepsy: Type [ ] Grand Mal [ ] Petite Mal [ ] Other
		Diabetes: Insulin Dependent: [ ] Yes [ ] No
		Asthma: Use inhaler [ ]Yes [ ] No
		Bee sting reactions Use Epi-Pen [ ] Yes [ ] No
		Allergic reaction to medicine If so, name
		Heart condition (Specify)

According to the Education Code, parents are required to inform the school if their child is on routine medication.
Name of medication:_____

Supervising Physician:_____

Is there a special health problem or physical disability that should be brought to the attention of the school nurse or teacher?

_____
_____
_____
_____
_____

Childhood illnesses: _____ Accidents: _____
Pupil's sleep and rest patterns: Average hours per night_____ Sleeps: quietly___ restless___ dreams___
walks in sleep___ bed wetter___ needs naps___ rested after night's sleep___

My child has had Special Services in a previous school. Yes___ No___ Please circle: Speech, Special Day Class, Resource Program, Psychological Testing, Adaptive Physical Education, Other: _____

_____ _____ _____
Signature of Parent or Guardian Relationship Date

If guardian, have guardianship papers been completed: Yes___ No___

HS-9b (2/11)

THIS IS A PERMANENT RECORD