Eanes Independent School District
Health Information *Update*

Name_____________________________Sex____Grade____Birthdate________Teacher_____________

Have any of the following occurred in the past year?

Condition	**Yes**	**No**	**Please explain "Yes" answers**
Asthma			
Blood Transfusions			
Broken Bones			
Diabetes			
Head Injury			
Heart Condition			
Rheumatic Fever			
Fainting Spells			
Seizures			
Surgery			
Vision or Hearing Problem			
Other			
Allergies:			
Medication			
Food			
Environmental			

Is he/she on medication?

Medication (Name & Strength)	Dose/Frequency	Days Taken	Home	School

*Is there any reason he/she can't participate in a full program, including physical education activities?
Yes/No If yes, please explain____

*Have there been any stressful events in your child's life that could have an impact on his emotional well being? Example: death or serious illness in immediate family, major economic changes, abusive behavior, recent divorce or remarriage?
Yes/No If yes, please explain____

*Has your child had chicken pox? **Yes/No If yes, when? (month/year)**________________________________

*Has your child had any recent immunizations? **Yes/No If yes, please attach physician documentation**.

Please give name, address and phone number of the doctor who last examined your child.

Name______________________________Address__________________________Phone_________________

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Date Signature of Parent/Guardian