

**STUDENT HEALTH RECORD
KETTERING CITY SCHOOL DISTRICT
HEALTH SERVICES - STUDENT SERVICES**

PARENTS: Complete Section I

SECTION I:

Date _____

Student's Name _____

Address _____

ZIP CODE _____

Student's Birthdate _____ Sex _____ Name of School _____

Name of Parent(s) or Guardian _____

Check the disease(s) your child has or has had:

Asthma _____ Diabetes _____ ADD _____ ADHD _____

Heart Disease _____ Chicken Pox _____ Cancer _____ Tuberculosis _____

Seizure Disorder _____ Other _____

Is your child on any medication? Yes _____ No _____

Please name medication and reason it's taken _____

Does student have a physical disability and/or limitation? Yes _____ No _____

Explain _____

Does student have any allergies? Yes _____ No _____

List allergies: _____

Would you say student is (check one) very active _____ average _____ quiet _____

Please state any health problems student may have that would be important for the school to know:

EXAMINING DENTIST: Complete Section II

SECTION II: Date of Examination _____

1. At this time, child has no apparent dental defects _____
2. Child is under regular dental care _____
3. Appointments have been made for correction of dental defects _____

Dentist Signature

(Have licensed medical provider complete other side)

