



Los Angeles Unified School District
Medical Services Division
Permanent Health History



Student's Name: _____ Birth Date: _____ Legal Sex: (Select One) [] Male [] Female [] Non-binary [] Intersex
Gender: (Select One) [] Male [] Female [] Non-Binary

Last School or Children's Center Attended: _____

Parent/Guardian's Name: _____ School: _____ Health Care Plan: _____
City, State: _____ Present Grade: _____ Primary Healthcare Provider: _____

Has Child Ever Been Hospitalized? [] Yes [] No

Name of Hospital _____
City _____ State _____
(Month/Year) _____
Reasons for Hospitalization _____

Is Child on Medication? [] Yes [] No

Name of Medication(s) _____
Name of Medication(s) _____
Name of Medication(s) _____
Name of Medication(s) _____

Are Physical Activities Limited? [] Yes [] No

If so, please explain: _____

Child's Illness (Past or Present) Please check all that apply:

- [] Asthma [] Kidney Problems
[] Blood Disease [] Measles
[] Chickenpox [] Meningitis
[] Diabetes [] Mumps
[] Drug or Other Allergy [] Positive Tuberculosis Skin Test
[] Eye Problem [] Rubella
[] Head Injury [] Seizures/Unconscious
[] Hearing Loss [] Speech Problem
[] Heart Condition/Murmur [] Wears Glasses/Contacts
[] High Blood Pressure [] Pertussis (Whooping Cough)
[] Hives or Eczema

* Other Serious Accidents or Illness (Describe) _____

Birth History:

Child's Birth Weight: _____ Describe any birth complications: _____

Do you have any questions or concerns about your child's health (related to current or past health, biological immediate family history, etc.)? _____

Parent/Guardian's Name: _____ Parent/Guardian's Signature: _____ Date: _____

