



**STUDENT HEALTH HISTORY  
CURRENT HEALTH INFORMATION**

● Information obtained from this health history will be included on a confidential health conditions list, if appropriate.

Does your child have any of the following medical conditions? Please check the appropriate boxes:

- Current seizures  
If checked, on medication?       Yes    No
- Current asthma  
If checked:   uses inhaler   on medication
- Diabetes  
If checked: Insulin dependent?    Yes    No
- Bee sting allergy  
If checked, requiring:    Epi-pen    Benadryl
- Behavior problems
- Hearing aids
- Movement limitations
- Prosthesis
- Speech problems
- Recent hospitalizations. If checked, please explain:  
\_\_\_\_\_
- Severe allergies requiring medication. If checked, please explain: \_\_\_\_\_
- Other (please explain):  
\_\_\_\_\_

- Vision or eye problems:     Yes     No  
If yes, wears glasses:  
     for board work  
     for reading  
     all the time  
Date of last eye exam: \_\_\_\_\_

- Medication: If your child requires medication at school, all medication sent to school must be in the prescription container with a current date and an "Authorization for Administration of Medication" form must be on file (obtain from the school office). Please indication:  
Medication: \_\_\_\_\_ Dsge: \_\_\_\_ Hr(s) given: \_\_\_\_\_  
  
Medication: \_\_\_\_\_ Dsge: \_\_\_\_ Hr(s) given: \_\_\_\_\_

**SPECIAL EDUCATION**

Does the student have an active IEP?

No    Yes

**If Yes, please attach a copy of the IEP with your application.**

	Date Entered	Date of Last IEP Meeting
<input type="checkbox"/> Mental Retardation <small>(10/MR)</small>		
<input type="checkbox"/> Hard of Hearing <small>(20/HH)</small>		
<input type="checkbox"/> Deaf <small>(30/Deaf)</small>		
<input type="checkbox"/> Specific Learning Disability, please name: _____ <small>(40/SLI)</small>		
<input type="checkbox"/> Visual Impairment <small>(50/VI)</small>		
<input type="checkbox"/> Emotional Disturbance <small>(60/ED)</small>		
<input type="checkbox"/> Orthopedic Impairment <small>(70/OI)</small>		
<input type="checkbox"/> Other Health Impairment, please specify: _____ <small>(80/OHI)</small>		
<input type="checkbox"/> Speech/Language Impairment <small>(90/SLD)</small>		
<input type="checkbox"/> Deaf-Blind <small>(100/DB)</small>		
<input type="checkbox"/> Multiple Disability, please specify which ones: _____ <small>(110/MD)</small>		
<input type="checkbox"/> Autism <small>(120/AUT)</small>		
<input type="checkbox"/> Traumatic Brain Injury <small>(130/TBI)</small>		

Please identify which school district developed the IEP:  
\_\_\_\_\_

**The undersigned declares that the address of the student given above is the true and correct primary residence of the child within the boundaries of the Bullis Charter School, and that the undersigned will immediately inform the School of any change in address which subsequently occurs.**

**The undersigned declares that the above information is true and correct to the best of his/her knowledge.**

Parent/Guardian signature

Date