STUDENT HEALTH HISTORY

TO INSURE PROPER CLASS PLACEMENT AND ATTENTION TO HIS/HER SPECIAL HEALTH CARE NEEDS, INFORMATION REGARDING THE HEALTH OF THIS CHILD MAY BE SHARED WITH APPROPRIATE SCHOOL PERSONNEL.

______________________	**ST. ALPHONSUS SCHOOL**	______________________
DATE	SCHOOL	SIGNATURE OF PARENT/GUARDIAN

CHILD'S NAME____SEX__________BIRTHDATE________________

ADDRESS____PHONE____________________

CITY/VILLAGE/TOWN____ ZIP ______________________

PARENTS/GUARDIAN____

HISTORY OF ILLNESS – CHECK (AND DATE) BELOW IF YOUR CHILD HAS HAD ANY OF THE FOLLOWING:

CHICKEN POX ______________________

MUMPS ______________________

WHOOPING COUGH ______________________

MEASLES (RED) ______________________

RUBELLA (GERMAN MEASLES) ______________________

SCARLET FEVER ______________________

STREP INFECTIONS ______________________

PNEUMONIA ______________________

RHEUMATIC FEVER ______________________

TUBERCULOSIS ______________________

EXPOSURE TO TUBERCULOSIS ______________________

FRACTURES (BROKEN BONES) ______________________

DIABETES______________________

EPILEPSY ______________________

HEART______________________

KIDNEY ______________________

HEPATITIS ______________________

ALLERGY ______________________

ASTHMA ______________________

CANCER ______________________

BLOOD DISORDER ______________________

SEIZURES ______________________

ARTHRITIS ______________________

EMOTIONAL ______________________

VISION/EYES ______________________

HEARING/EARS ______________________

OTHER ILLNESS/INJURY/CONDITION: ____

HOSPITALIZATIONS/SURGERY: ____

CONGENITAL ABNORMALITY OR ORTHOPEDIC CONDITION: ______________________________

CORRECTIVE MEASURES: ____

DOES YOUR CHILD NOW HAVE ANY RELATED PROBLEMS DUE TO ANY OF THE ABOVE CONDITIONS?

____

WILL YOUR CHILD NEED ANY SPECIAL CLASSROOM PLACEMENT OR ATTENTION DUE TO THIS?

____

CONTINUED ON OTHER SIDE – OVER, PLEASE

HEALTH HISTORY

YES **NO**

DID MOTHER HAVE A HEALTHY, UNCOMPLICATED PREGNANCY, LABOR AND DELIVERY? ____ ____

LIST ANY HEALTH PROBLEMS AT TIME OF BIRTH OR DURING INFANCY?

____ ____ ____

____

DO YOU HAVE ANY SPECIFIC CONCERNS ABOUT YOUR CHILD'S GROWTH AND DEVELOPMENT? ____ ____

IF YES, EXPLAIN ____

HAS YOUR CHILD BEEN UNDER A PHYSICIAN'S CARE DURING THE LAST 12 MONTHS? _________ ____ ____

IF YES, EXPLAIN____

HAS YOUR CHILD BEEN UNDER A DENTIST'S CARE DURING THE LAST 12 MONTHS? ____ ____

ROUTINE CARE__________________________ OTHER________________________________ ____ ____

IS YOUR CHILD RECEIVING ANY MEDICATIONS NOW, OR DURING THE PAST 12 MONTHS? ____ ____

IF YES, LIST NAME AND FOR WHAT PURPOSE ____________________________________

____

IS THERE ANYTHING ABOUT YOUR CHILD'S HEALTH THAT CONCERNS YOU? ____ ____

IF YES, EXPLAIN____

WOULD YOU LIKE THE SCHOOL NURSE TO CONTACT YOU AT THIS TIME TO DISCUSS

THIS OR ANY OTHER HEALTH CONCERNS? ____ ____

____

____

HAS THIS CHILD RECEIVED ANY IMMUNIZATIONS FROM THE GREENDALE HEALTH DEPARTMENT? ____ ____