HEALTH HISTORY

Name of Student _____ Birthdate _____ Sex: M F Grade _____

A. Medical History (Please check the ones that apply to your child.)

____ Asthma	____ Frequent sore throats	____ Frequent headaches
____ Hay Fever	____ Frequent ear infections	____ Frequent stomach aches
____ Diabetes	____ Frequent colds	____ Poor appetite
____ Bleeder	____ Speech difficulty	____ Dental problems
____ Heart Disease	____ Convulsions w/ high fever	____ Color blindness
____ Seizures	____ Fainting spells	____ Physical handicap
____ Vision problem	____ Frequent nose bleeds	____ Hearing problem

B. Allergies: ____ plants ____ foods ____ bees or insects ____ drugs ____ animals ____ other _____

Please describe the allergic reaction _____

C. Is medication needed for allergy? At home? Yes ____ No ____ Name of medication _____
At School? Yes ____ No ____

Is medication needed for any other condition? At home? Yes ____ No ____ Name of medication _____
At school? Yes ____ No ____ Condition _____

D. Was there a health problem and/or handicap present at birth? Yes ____ No ____

At what age was the diagnosis made? _____ Diagnosis:_____

Please list physicians or agencies which made the diagnosis:_____

E. Please list any operation, injuries or hospitalizations. Give dates. _____

_____

F. Physical education activity is: Limited ____ Not limited ____
If activity is to be limited, please explain and <u>attach</u> written instructions from the physician._____

G. Does your child wear contact lenses? Yes ____ No ____ Glasses? Yes ____ No ____

H. Last eye examination (date) _____ by Dr. _____
Last dental examination (date) _____ by Dr. _____
Last medical examination (date) _____ by Dr. _____

I. Is there anything you can tell us about your child that you feel will help the school staff to better understand and work with him/her? _____

AUTHORIZATION FOR EMERGENCY PROCEDURE

If the parents and authorized physician named on the registration record cannot be reached at the time of an emergency, and if immediate observation or treatment is urgent in the judgment of school authorities, I authorize and direct the St. Frances Cabrini School authorities to send the student (properly accompanied) to the hospital or doctor most easily accessible. I understand that I will assume full responsibility for the payment of any services rendered.

Hospital Preference _____

_____ _____ _____
Date Signature of parent or guardian Telephone