ST. JEROME
CATHOLIC SCHOOL

HEALTH HISTORY FORM
20__ - 20__

Student's Name: _____ Age: _____ Grade: _____

Please circle any of the following that your child has or has ever had:

1. Allergies
2. Asthma
3. Bone Disorders
4. Diabetes
5. Heart or Cardiac Disease
6. Kidney Disease
7. Rheumatic Fever
8. Tuberculosis (or contact with active case yes or no)
9. Sickle Cell Anemia
10. Seizures
    a. Frequent Fainting
    b. Convulsions
    c. Frequent Dizziness
    d. Tremors
11. Hearing Loss
12. Vision Loss
13. Psychiatric-Psychological
14. Learning Disability

Indicate if he/she has had the usual childhood diseases:
a. Measles _____ b. Mumps _____ c. Chickenpox _____ d. Other _____

Any Specific Symptoms we should know about such as:
1. Frequent Headaches 2. Frequent Stomach Aches 3. Nosebleeds
4. Frequent colds, sore throats 5. Other _____

Is your child now under a Physician's Care? _____
If so, for what condition: _____

If you circled anything above, please list condition, medications and dosage below:

As part of our school health services your child may be provided with Visual, Hearing and Dental Inspection. You will be informed when your child is found to have a deviation from normal, so that he/she can be further checked by your private physician. Please indicate your permission for your child to participate in the screening programs? Yes _____ No _____

Telephone number where you can be reached in case of emergency?

_____, _____ and _____
Home Work Cell

Date your child had last physical examination? _____

_____ _____
Parent Signature Date