Holy Family School
Health History Form

Name of Child_____ Date of Birth_____

Check any problem you child has had:

_____Allergy (explain) _____
_____Bee Sting 1. Severe local reaction 2. Requires emergency care
_____Food_____
_____Pollen_____
_____Other_____
_____Asthma (explain) _____
_____Use of inhaler/nebulizer at school
_____Anemia
_____Arthritis
_____Cancer
_____Constipation
_____Dental
_____Diabetes (explain) _____
_____Eczema
_____Epistaxis (Nose Bleeds)
_____Episode of fainting, convulsions
_____Frequent Colds
_____Frequent Stomach Aches
_____Hearing Difficulty
_____Hepatitis
_____High Blood Pressure
_____Lead Poisoning
_____Muscle/Bone/Joint
_____Overweight
_____Physical Impairment
_____Seizures
_____Sleep Disturbance
_____Speech Difficulty
_____Tuberculosis
_____Underweight
_____Urination/Kidney (explain) _____
_____Vision Problem (explain) _____
_____Wears glasses/contacts

Is your child under treatment at the present time? No____ Yes____ If yes explain _____

_____

Detail any present/past illnesses, surgeries, and/or hospitalizations.

_____

_____

Current medications: _____

Physicals with Immunizations are required in K and 6th Grades.

Dental reports are required in K, 3rd, and 7th Grades.

Check contagious diseases your child has had:

	(Age)		(Age)
_____Chickenpox	_____	_____Pneumonia	_____
_____Diphtheria	_____	_____Poliomyelitis	_____
_____German Measles	_____	_____Rheumatic Fever	_____
_____Measles	_____	_____Scarlet Fever	_____
_____Meningitis	_____	_____Strep Throat	_____
_____Mono	_____	_____Typhoid Fever	_____
_____Mumps	_____	_____Whooping Cough	_____

Parent/Guardian Signature: _____