SAINT JOSEPH SCHOOL

Health History

2021–2022 HEALTH HISTORY

One per child

Student Last Name	Student First Name	Birthdate	Age
Entering Grade	Teacher		Male/Female

PRENATAL / INFANCY

Was child born full term? Y / N	If premature, how many weeks early?	Birth weight
Were there any problems during labor, birth or early infancy? Y / N If yes, please explain		

MEDICAL HISTORY Does your child have allergies? Y / N If yes, please explain

ALLERGIC to:

PLANT ☐	ANIMAL ☐	FOOD ☐	BEE/INSECT ☐	MEDICATION ☐	ENVIRONMENT ☐	OTHER ☐
Type of Reaction:		LOCAL ☐		ANAPHYLACTIC ☐		
Required Response:	EPI-PEN ☐		EPI-PEN JR. ☐	BENADRYL ☐	OTHER	

ILLNESS OR DEVELOPMENT PROBLEMS NONE please check any of the following that the child has:

1. Asthma ☐	7. Convulsions/Seizures ☐	13. Ear Infections ☐	19. Skin ☐
2. Bleeding ☐	8. Cystic Fibrosis ☐	14. Heart Problems ☐	20. Speech ☐
3. Bone / Muscle ☐	9. Cerebral Palsy ☐	15. Hearing ☐	21. Stomach ☐
4. Bowel ☐	10. Dental ☐	16. Meningitis ☐	22. Urinary / Bladder ☐
5. Cancer / Leukemia ☐	11. Diabetes ☐	17. Sickle Cell Anemia ☐	23. Special Diet ☐
6. Attention / Learning ☐	12. Emotional / Behavioral ☐	18. Vision ☐	24. Special Equipment ☐

For those illnesses or developmental problems checked above and any other surgery, hospitalization, injury/accident, family history, or other significant past or present medical problem, please provide additional information. Use the reverse side if needed.

Does your child take **MEDICATION** on a regular basis? Y / N If yes, please list:

Medication	Dose	Time of Day Taken
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May your child fully participate in recess/physical education? Y / N If no, please explain restrictions

Do you have any other health information regarding your child that the school nurse should know? Y / N (ex: recent changes in child's life)

Please explain if yes, and use the reverse side if necessary.

Signature _____ Relationship _____ Date _____