ST PHILIP SCHOOL

HEALTH HISTORY

Student's Name _____ School _____
(Last) (First) (Middle)

Grade _____

Address _____ Birth Date _____

_____ Phone _____

Father _____ Male _____ Female _____
(Last) (First) (MI)

Race _____

Mother _____
(Last) (First) (MI)

Person with whom student lives if other than parent

_____ Relationship _____

Student's Physician _____ Phone _____

Student's Dentist _____ Phone _____

Medical History (since birth) Check and give date:

Allergies _____
Anemia _____
Asthma _____
Bee sting reaction _____
Chicken Pox _____
Colds (frequent) _____
Diabetes _____
Drug Reaction _____
Ear problems _____
Eczema _____
Emotional problem _____
Eye problems _____
Fainting spells _____
Headaches (frequent) _____
Heart Disease _____
Hepatitis _____
Hernia _____
Hyperactivity _____
Injuries/fractures _____
Joint/muscle pain _____
Kidney disease _____
Meningitis _____
Mononucleosis _____
Nose bleeds (severe) _____
Operations _____
Other illnesses _____
Pneumonia _____
Premature birth _____
Seizures _____
Speech problem _____
Strep throat _____
Tonsillitis _____
Tuberculosis _____

*Please give details on any of the above or provide other pertinent health information on the back of the paper.

Is your child under medical care now? _____ If so, for what reason? _____

Does your child take medication regularly? _____ Medication _____

For what reason? _____

Under what health insurance is your child covered? _____

_____ _____
(Date) Signature of Parent / Guardian