SAINT PIUS TENTH SCHOOL

STUDENT HISTORY

Student's Name _____ Sex _____ Date of Birth _____

Physician's Name _____
Physician's Address _____
_____

Has your child ever had any of the following? If "yes" please comment.

	NO	Yes	Comment
Allergies	_____	_____	_____
Asthma	_____	_____	_____
Diabetes	_____	_____	_____
Seizures	_____	_____	_____
Bleeding Tendencies	_____	_____	_____
Heart Disease	_____	_____	_____
Tuberculosis contact	_____	_____	_____
Rheumatic Fever	_____	_____	_____
Severe Headaches	_____	_____	_____
Chicken Pox	_____	_____	_____
Cancer	_____	_____	_____
Leukemia	_____	_____	_____
Vision Problems	_____	_____	_____
Hearing Problems	_____	_____	_____
Speech Problems	_____	_____	_____
Orthopedic Problems	_____	_____	_____
Other _____	_____	_____	_____

Approximate date of the most recent physical examination _____ exam was done by:

_____ _____
Physician's Name Physician's Address

Has your child had any operations (including tonsillectomy)? _____ When? _____

Has your child had any serious accidents or injuries? _____ When? _____

Is your child now or has he/she ever been on any regular medications? _____ When? _____

Explain _____

Does your child have any special health problems or restrictions? _____ Explain _____

_____

_____ _____
Date Parent Signature

I give permission for the above health history information to be shared with appropriate school personnel as necessary to promote the health and education of my child.

_____ _____
Date Parent Signature