Health History Form

This form must be completed by parents for all new students and yearly thereafter.

Child's Name	Sex	Birthdate

Father	Address

Father Home phone	Father Work Phone	Father Cell Phone

Mother (maiden name)	Mother (present name)

Address

Mother Home phone	Mother Work Phone	Mother Cell Phone

Physician	Phone	Hospital Preference

If parents are not available, in an emergency contact:	Name	Phone
	Name	Phone

Have you traveled outside the country within the last year? ____ If so, where? _____

Illness & Conditions the Child Has Had or Has Presently (give dates)

Anemia	Heart Disease	Rheumatic Fever
Chicken Pox	Ear Infections	Frequent Colds
German Measles (Rubella)	Speech Problems	Frequent Sore Throats
Measles	Cleft Palate	Eye Problems
Scarlet Fever	Asthma	Seizures
Mumps	Diabetes Child	Wears Glasses
Pneumonia	Diabetes Family	Contact w/Tuberculosis

Serious Accidents, Operations, Other Illnesses, X-Rays, Handicap, etc. (give dates) _____

_____

Special Dietary Needs _____

Allergies (please describe) _____

Growth and Development

Birth Weight	Delivery		Bed Wetting/Bowel Accidents Y N
Walked at Age	Talked at Age	Toilet Trained at Age	Dental Care

Parent Signature_____ Date _____