

# HEALTH RECORD FORM

Dear Parent/Guardian:

To assist us in doing an efficient job of safeguarding the health of your children, would you please supply the information requested on this form and return it to the **Health Office**. Please complete **BOTH SIDES** of this form. **Please notify the school when you are keeping your child home due to illness.**

**Jim Plesniarski, *Principal***

**Date Returned:** \_\_\_\_\_



Child's Name \_\_\_\_\_ Age \_\_\_\_\_ Sex \_\_\_\_\_

911 Address \_\_\_\_\_

\_\_\_\_\_ Phone \_\_\_\_\_

Grade \_\_\_\_\_ Date of Birth \_\_\_\_\_ Place of Birth \_\_\_\_\_

Father's Name \_\_\_\_\_ Do you live in the student's home  Yes  No

Employer address & phone number \_\_\_\_\_

Mother's Name \_\_\_\_\_ Do you live in the student's home  Yes  No

Employer address & phone number \_\_\_\_\_

**Who can we contact, other than yourself, in case of accident or illness at school?**

\_\_\_\_\_

Family Physician - Address & Phone \_\_\_\_\_

Family Dentist - Address & Phone \_\_\_\_\_

**BROTHERS AND SISTERS**

<u>Name</u>	<u>Date of Birth</u>	<u>Living at Home?</u>	<u>Grade / School / Occupation</u>
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

**SEE OTHER SIDE**

# PAST HISTORY OF ILLNESS



## COMMUNICABLE DISEASES

Chicken pox (date) \_\_\_\_\_  
 Fifth Disease (date) \_\_\_\_\_  
 Scarletina (date) \_\_\_\_\_  
 Whooping Cough (date) \_\_\_\_\_  
 Other: \_\_\_\_\_  
 \_\_\_\_\_

## OTHER DISEASES

Asthma - if so, medication \_\_\_\_\_  
 Diabetes \_\_\_\_\_  
 Epilepsy / Seizures - if so, medication \_\_\_\_\_  
 \_\_\_\_\_  
 Heart Problems \_\_\_\_\_  
 Kidney Problems \_\_\_\_\_



## ALLERGIES



Allergy to Medication \_\_\_\_\_  
 Other: \_\_\_\_\_

Reaction \_\_\_\_\_  
 Reaction \_\_\_\_\_



## OTHER CONDITIONS



*If your child has experienced any of the health problems below, please check the appropriate box or boxes.*

- |  |   |   |  |
|--|---|---|--|
| <input type="checkbox"/> Frequent Ear Infections                 | <input type="checkbox"/> Frequent Throat Infections | <input type="checkbox"/> Constant Cough     | <input type="checkbox"/> Frequent Colds  |
| <input type="checkbox"/> Hearing Difficulty                      | <input type="checkbox"/> Vision Difficulty          | <input type="checkbox"/> Speech Problems    | <input type="checkbox"/> Fainting Spells |
| <input type="checkbox"/> Bed Wetting                             | <input type="checkbox"/> Recurrent Constipation     | <input type="checkbox"/> Recurrent Diarrhea |  |
| <input type="checkbox"/> Recurrent Urinary or Bladder Infections | <input type="checkbox"/> Other                      |   |  |

Are there any foods your child CANNOT eat? \_\_\_\_\_

Are there any foods you child is ALLERGIC to? \_\_\_\_\_

Has your child had any illness, injury, or operation during the past year? \_\_\_\_\_  
 \_\_\_\_\_

Has your child ever had any type of surgery? \_\_\_\_\_  
 \_\_\_\_\_

Is your child under treatment at the present time for ANY conditions? \_\_\_\_\_

If yes, what is the condition? \_\_\_\_\_

What is the treatment? \_\_\_\_\_

Is your child on ANY MEDICATION at the present time? If so, please list medication and reason for its use \_\_\_\_\_  
 \_\_\_\_\_

Additional information that may help us care for your child \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_