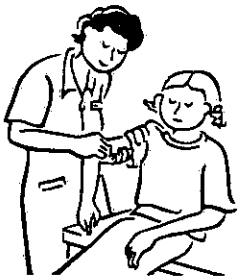

St. Mary School - Vermilion

Student Health History

Date:_____

Student Name:_____DOB:_____ Grade:_____
Weight_____ Height_____

**Please use immunization record form on back or submit a copy for our records.

1. Birth defects Yes____ No____
2. Meningitis Yes____ No____
3. Blood disorder Yes____ No____
4. Diabetes Yes____ No____
5. Seizures Yes____ No____
6. TB/TB Contact Yes____ No____
7. Ear Infections Yes____ No____
8. Speech problems Yes____ No____
9. Serious illness Yes____ No____
10. Serious injuries Yes____ No____
11. Ear/hearing Problems Yes____ No____
12. Eye/vision Problems Yes____ No____
13. Asthma Yes____ No____
14. Inhaler Yes____ No____
    *needed at school Yes____ No____
15. Bone/joint
16. Problems Yes____ No____
17. High Blood
18. Pressure Yes____ No____
19. Surgery Yes____ No____
20. If yes explain_____
    _____
    _____
21. Hospitalization Yes____ No____

If yes, explain_____
_____
_____
_____

22. Allergies Yes____ No____

Type:_____
_____
_____
_____

23. Current Medications Yes____ No____

List_____
_____
_____

If medication is needed to be administered at school, a physician must complete a medication order. Forms are available from the school nurse. **Please indicate specific information on any current medical problem(s).

Type of problem and history:_____
_____
_____
_____

Limitations:
_____
_____

Restrictions on activities:
_____
_____

(If restrictions/ limitations are necessary, please include a doctor's statement)

Medical specialists involved:

_____

Address and phone:
_____
_____

Comments:_____
_____
_____
_____

Physician's Name:_____

Office phone_____

_____

Physician's Signature Date

over