



# Sacred Heart Catholic School

Gervais

## PUPIL MEDICAL RECORD Confidential Information

Student's Name \_\_\_\_\_ School Sacred Heart Catholic School Grade \_\_\_\_ Birthday \_\_\_\_\_ Sex: M F

Address: \_\_\_\_\_ Phone: \_\_\_\_\_  
Street or P.O. Box City State Zip

Parent or Guardian \_\_\_\_\_ Father Wk. Ph. \_\_\_\_\_ Mother Wk. Ph. \_\_\_\_\_

Name of Physician \_\_\_\_\_ Phone: \_\_\_\_\_

### PARENT'S EVALUATION OF STUDENT'S HEALTH

1. Does your student have a physical handicap? If yes, please state the nature of the condition:	<input type="checkbox"/> YES <input type="checkbox"/> NO	
2. Has your student ever had an operation? If yes, please state nature of operation and date performed:	<input type="checkbox"/> YES <input type="checkbox"/> NO	
3. Has your student ever had a severe injury? If yes, please explain and give date of injury:	<input type="checkbox"/> YES <input type="checkbox"/> NO	
4. Does your student have any of the following?		
<input type="checkbox"/> ADD/ADHD		
<input type="checkbox"/> Asthma <i>Please circle applicable triggers: Animal Dander, Dust/Dust Mites, Exercise Induced, Mold</i>		
<input type="checkbox"/> Bladder/Bowel Disorder		
<input type="checkbox"/> Blood Disorder		
<input type="checkbox"/> Brain Injury		
<input type="checkbox"/> Diabetes <i>Please circle: Type 1 Type 2</i>		
<input type="checkbox"/> Ear/Eye Disorder		
<input type="checkbox"/> Heart Problem		
<input type="checkbox"/> Seizure Disorder		
<input type="checkbox"/> Severe Allergy with Epinephrine prescribed. <i>Please specify allergen:</i>		
<input type="checkbox"/> Suppressed Immune System		
<input type="checkbox"/> Other health problems <i>Please specify:</i>		
5. Is your student presently under a doctor's care for a particular illness? If so, please state nature of illness:	<input type="checkbox"/> YES <input type="checkbox"/> NO	
6. Is he/she taking medication? If yes, should he/she take medication at school? Please state nature of illness and name of medication:	<input type="checkbox"/> YES <input type="checkbox"/> NO	<i>Note:</i> An additional form must be completed for all medications taken at school.
7. Is your student able to participate in full activity at school? If no, please explain:	<input type="checkbox"/> YES <input type="checkbox"/> NO	
8. Has your student been hospitalized recently?	<input type="checkbox"/> YES <input type="checkbox"/> NO	If yes, what year? _____
_____ SIGNATURE OF PARENT OR LEGAL GUARDIAN		_____ DATE