Saints Philip and James School

Student Health History

Student: _____ Grade _____ Date of birth_____

Please check if your child has/had any of the following conditions:

_____Arthritis
_____Asthma
_____Anemia
_____ADD/ADHD
_____Auditory Processing Disorder
_____Bowel problems
_____Cancer
_____Celiac Disease
_____Chronic Bronchitis
_____Color deficiency
_____Concussions
_____Coordination problems
_____Cystic Fibrosis
_____Diabetes
_____Ear Infections
_____Eczema
_____Epilepsy/Seizures
_____Fainting Spells
_____Food Allergies
_____Headaches (frequent)
_____Head Injury
_____Hearing difficulties
_____Heart Problems
_____Heart Murmur
_____Hepatitis
_____Hernia
_____High Blood Pressure
_____Kidney Disease
_____Learning Difficulties
_____Leukemia
_____Liver problems
_____Nosebleeds
_____OCD
_____Physical Handicap
_____Pneumonia
_____Scoliosis
_____Sinusitis
_____Skin Problems/ rashes
_____Speech/Language difficulty
_____Stomach problems
_____Strep Throat/ infections
_____Tuberculosis
_____Urinary issues/incontinence
_____Whooping cough/Pertussis

Other: (please explain)_____

_____

Parent Signature: _____ Date: _____