South Hills Catholic Academy

STUDENT HEALTH HISTORY

Student's Name _____ Grade _____ Date of Birth _____

Street Address _____

City _____ Zip _____ Cell/Primary Phone _____

Siblings Name	Birth Date	School	Grade

Name and address of school last attended:

Name of School:

Address of School:

Physician: _____ **Phone Number** _____

Dentist: _____ **Phone Number** _____

Medication: (please list all medications taken):

At Home: _____

At School: _____

*(If required at school, complete form #**440-Authorization for Medicine**)*

OVER

STUDENT NAME: _____ **GRADE** _____

TO BE COMPLETED BY PARENT/GUARDIAN

Please check ✓ ALL that applies to your child

Anxiety	☐	*Developmental Delay*	☐	*Nosebleeds*	☐
Arthritis	☐	*Diabetes Type 1*	☐	*Orthopedic Condition*	☐
Asthma	☐	*Diabetes Type 2*	☐	*Rheumatic Disease*	☐
Attention Deficit Disorder	☐	*Dietary Restrictions*	☐	*Sickle Cell*	☐
Autoimmune Disorder	☐	*Epilepsy/Seizure Disorder*	☐	*Speech Difficulty*	☐
Bladder/Bowel Control	☐	*Gastrointestinal Condition*	☐	*Spina Bifida*	☐
Bleeding Disorder	☐	*Hearing Deficit – right / left*	☐	*TB Exposure*	☐
Blood Pressure Issues – high or low	☐	*Immunocompromised*	☐	*Thyroid Condition – Specify*	☐
Cancer	☐	*Inflammatory Bowel Disease*	☐	*Tourette's Syndrome*	☐
Cardiovascular Condition – Specify	☐	*Kidney Condition*	☐	*Vision: Eye Surgery – Specify*	☐
Cerebral Palsy	☐	*Mental Health Diagnosis*	☐	*Severe Vision Loss – right / left*	☐
Chicken Pox (date)	☐	*Migraines*	☐		
Color Vision Deficiency	☐	*Neurological Disorder*	☐		
Dental Condition	☐		☐		

Explain Above Check Marks: _____

Allergies/Reaction: _____

Previous Surgeries/Dates: _____

Other: _____

I understand and agree that any and all of this information may be shared with appropriate school personnel.

_____ _____

Parent/Guardian Signature Date

_____ _____

Signature of Certified School Nurse Date