HEALTH HISTORY FORM

HOLY FAMILY SCHOOL ~ (Page 1 of 2)

221 Third Avenue

Phoenixville, PA 19460

(PLEASE PRINT CLEARLY AND FILL IN ALL INFORMATION)

(Please ✔) Male____ Female____ Date_____

Name of Child_____Date of Birth_____
Last First Middle

Address_____
Street City State Zip

Home Telephone_____

Father's Name _____ Mother's Name _____
Last First Middle Last First Middle

Legal Guardian _____

Family Physician _____ Telephone No._____

Last School Child Attended_____

Check any problem your child has had:

___Allergy(explain)_____
_____Bee Sting
1. Severe local reaction 2. Required emergency care
_____Food_____
_____Pollens_____
_____Other_____
___Asthma (explain)_____
___Use of Inhaler/Nebulizer at school
___Anemia
___Arthritis
___Cancer
___Constipation
___Dental
___Diabetes (explain)_____
___Eczema

___Epistaxis (Nose bleeds)
___Episode of Fainting, Convulsions
___Frequent Colds
___Frequent Stomachaches

____Hearing Difficulty
____Hepatitis

____High Blood Pressure
____Lead Poisoning
____Lead Poisoning
____Muscle/Bone/Joint
____Overweight
____Physical Impairment
____Seizures
____Sleep Disturbance
____Speech Difficulty
____Tuberculosis
____Underweight
____Urination/Kidney Problem (explain)_____
____Vision Problem (explain) _____
____Wears Glasses

Is your child under treatment at the present time? _____Yes _____No

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Student Name_____

Detail any present/past illness, surgery, operations, and hospitalizations:

_____

_____

_____

Medication(s) your child is currently taking_____

_____

_____

Check any contagious disease(s) your child has had:

	Age		**Age**
____Chickenpox	____	____Pneumonia	____
____Diphtheria	____	____Poliomyelitis	____
____German Measles	____	____Rheumatic Fever	____
____Measles	____	____Scarlet Fever	____
____Meningitis	____	____Strep Throat	____
____Mono	____	____Typhoid Fever	____
____Mumps	____	____Whooping Cough	____

PLEASE ATTACH A COPY OF YOUR CHILD'S CURRENT IMMUNIZATION RECORD

Please update your child's immunization record annually

Objection on religious/moral or medical grounds? Yes_____ No_____
Please note, if yes a written statement must be provided.

Signature_____Date_____

Relationship to child: Parent_____ Guardian_____ Healthcare Provider_____