Our Lady of Grace School Health History **Student Grade for 2019-2020 _____**

Student Name_____ Date of Birth_____ Gender (circle) M F

Home Address_____

PAST MEDICAL HISTORY: Mark those that apply and give dates or age problem occurred.

Allergy_____
Environmental_____
Food_____
Bee Sting _____
Asthma_____
Arthritis_____
ADD/ADHD _____
Anemia_____
Bed Wetting_____
Bronchitis_____
Bone or Joint Problems _____
Birth Defect_____
Bleeding Disorder_____
Chickenpox_____
Convulsions_____
Cystic Fibrosis _____
Diabetes_____
Eating Disorder_____
Endocrine_____
Tuberculosis_____

Heart _____
Heart Disease_____
Heart Murmur_____
Headache_____
Hernia _____
Hypertension_____
Immune Disorder_____
Malignancies _____
Neurological Disorder _____
Pneumonia_____
Psychiatric Disorder _____
Rheumatic Fever_____
Scarlet Fever_____
Seizure Disorder_____
Serious Accidents_____
Sickle Cell Anemia_____
Skin Conditions_____
Surgery/Operations_____
Speech Problems_____
Other _____

Has your child had any difficulty with ears/hearing such as frequent infections, tubes, hearing loss, aides YES NO
If yes, please explain and include the name of treating physician:_____

Does your child presently have tubes in his/her ears? YES NO

Has your child had any difficulty with eyes/vision, such as "lazy eyes"/ vision/amblyopic, surgery, etc. YES NO
If yes, please explain and include the name of treating physician: _____

Does your child wear glasses or contact lenses YES NO
If yes, when was his/her last exam and who was the physician:_____

Does your child have environmental/food allergies? YES NO
If yes, please list:_____
If your child has allergies, how are they treated?_____

Does your child require medication for bee stings prescribed by a physician? YES NO
If yes, please provide the school nurse with the required medication as well as a written physician order.

Has your child been diagnosed with asthma by a physician YES NO
If so, what month_____ year _____ Is your child taking medication for asthma? YES NO
If yes, please explain_____

Is your child on medication at home? YES NO If yes, please explain_____

Will your child require medication at school? YES NO If yes, please explain_____

Any restrictions for Physical Education Class? YES NO If yes, please explain_____

Any other problems the nurse or teacher should be aware of? YES NO If yes, please explain_____

Signature of Parent/Guardian_____ Date_____