SACRED HEART SCHOOL
HEALTH HISTORY INFORMATION

Student Name _____ Grade _____ Date _____

At the beginning of the school year we will be doing the following Health Screenings: Hearing, Vision, Blood Pressure, Height and Weight, and Dental. Is your child allowed to participate in these Health Screenings?
YES NO

* Does your child have, or has your child had any of the following conditions? Check all that apply.

☐ **ADD/ADHD**

☐ **Allergic to-**
Bee Sting/Wasp

☐ Food Allergy -
List below

☐ Allergic to any Medication -
List below

☐ **Allergy - Seasonal**

☐ Allergy-Other
List below

☐ Asthma
Doctor Diagnosed

☐ **Diabetes**

☐ Eating Disorder
Please explain below

☐ **Epilepsy**

☐ **Eczema or Psoriasis**

☐ **Frequent Headaches**
(Not migraines)

☐ Migraines

☐ **Nose Bleeds**

☐ **Frequent Sore Throat**

☐ **Frequent Stomach pain**

☐ **Hearing Problems**

☐ Hearing Aid
Which ear? L / R

☐ Heart Disease/defect
Please explain below

☐ **Immune Deficiency Disorder**

☐ **Muscular Dystrophy**

☐ **Vision Problems**
Glasses / Contacts

☐ Physical Limitations
Please explain below

☐ **Scoliosis**

☐ **Sinus Problems**

☐ **Other** _____

Please explain anything checked from above: _____

_____

Does your child take daily medication at home? ☐No ☐Yes, Please list dose and reason:

_____

Is medication to be taken at school? ☐No ☐Yes, Please list dose and reason:

_____

_____

Does child take medication for emergency/seasonal use only? ☐No ☐Yes, Please list: _____

_____

_____

Medication given at school requires parents to fill out and sign a "Medication Administration Sheet" on each medication. These forms are available in the Health Office.

Health Form: Health Information Sheet (Rev March 13)