

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 _____

Last First Middle

Mother's Name _____

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
<input type="checkbox"/> Chickenpox	_____	<input type="checkbox"/> Pneumonia	_____
<input type="checkbox"/> Diphtheria	_____	<input type="checkbox"/> Poliomyelitis	_____
<input type="checkbox"/> German Measles	_____	<input type="checkbox"/> Rheumatic Fever	_____
<input type="checkbox"/> Measles	_____	<input type="checkbox"/> Scarlet Fever	_____
<input type="checkbox"/> Meningitis	_____	<input type="checkbox"/> Strep Throat	_____
<input type="checkbox"/> Mono	_____	<input type="checkbox"/> Typhoid Fever	_____
<input type="checkbox"/> Mumps	_____	<input type="checkbox"/> 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 _____