Our Lady of Mount Carmel School
School Health Services Health History
(Must be completed upon enrollment)

****A copy of the student's current immunizations is also required to register.***

To Parents or Guardian: The following information is requested for our records.

Grade Entering ______________ Date __________________

Previous school ________________________________State____

Student's Name ___________________________________ ______________Home Phone _____________________
Last First Middle

Birth date ___________________________ Male_____ Female_____
Month/Day/Year

Father's Name_________________________________ Mother's Name_______________________________
Last First Last First

Guardian (if applicable) ____ Relationship __________________
Last First

Mailing Address: ____
Street City/Town/State Zip

Email Address: ____
Father Mother

Parent's Work Phone:___________________________

Student's Physician ___________________ Date of last exam ________ Health Insurance_____________
Student's Dentist ____________________ Date of last exam _________ Dental Insurance______________

A. Disease History/ Illnesses:

Check any of the following and put a date next to all that apply.

Chicken Pox _______ __Lyme Disease _________ Kidney Disease Bleeding Disorder___________
Pneumonia Heart Disease __________ Gastrointestinal Seizure Disorder______________
Diabetes ADD ADHD ______________ Headaches Skin Disorder _________________
Please describe: ____

B. Health History: Please circle yes or no.

1. Does your child have frequent ear infections or trouble hearing? No Yes
2. Does your child have any trouble with eyes or vision? No Yes
3. Has your child ever had a serious illness? No Yes
4. Has your child ever had any surgery? No Yes

Please describe if the answer was "yes" to any of the above questions:

____

____

Please turn page over and complete the other side

C. Allergy History:

1. Does your child have any environmental allergies? No Yes
Explain ____

2. Has your child ever had an allergic reaction to **any** medications? No Yes
Please describe what happened. ____

3. Has your child had an allergic reaction to any foods? No Yes
Please describe what happened.____

4. Has your child ever had an adverse reaction to an insect sting? No Yes
Please describe what happened. ____

5. Does your child have asthma? No Yes

A. What type of asthma (allergic, exercise induced, etc.)?
____

B. Your child's best Peak Flow reading______________________

C. Please list any medication(s) your child takes for asthma and the frequency it is taken.
____
____

D. **Medication History:**

Does your child take medication on a daily basis? No Yes

Please list any medications taken and describe what the medication is for.
____
____

Has your child ever had a serious illness ? No Yes

If so, what and when ?

____

E. Social History:

Have there been any changes in your family during the past year, such as:

1. Separation, divorce, or remarriage? No Yes
2. Death or serious illness? No Yes
3. Any other situation which may affect your son/daughter? No Yes
If yes, please explain
____

F: Miscellaneous

Please list any condition your child may have which might limit his/her activities in school. Please include any other comments you think might be helpful.
____
____
____
____

Thank you for completing this form