St. Francis de Sales Catholic School
Student Health History Update

Please complete and return to the school nurse. This will assist in keeping an up-to-date Student Health Record on file. This information will be shared with staff and administration on a NEED TO KNOW basis unless you notify us otherwise.

_____ Date: Grade:_____

Name: _____

Birthdate:_____ Sex: [ ] M [ ] F

School attended last year: [ ] SFdS [ ] Other:_____

1. Please check if your child has been diagnosed, has a history of, or has any difficulty with the following conditions. Give additional information under comments, if necessary.

	ADD/ADHD		Epilepsy/Seizures		Measles		Surgery (specify):
	Asthma		Fractures (specify)		Menstruation Date of Onset:_____		
	Behavior Problems		Frequent Ear Infections		Mononucleosis		Tuberculosis
	Bleeding Disorder		Hearing Difficulty		Mumps		Vision Difficulty
	Bowel/Bladder		Hypertension (High BP)		Pneumonia		Weight Problems
	Chicken Pox		Infections		Speech Difficulty		Other (specify):
	Diabetes		Lyme Disease		Strep Throat		
	Emotional		Migraine Headaches				None of the listed conditions apply

Comments:_____
_____
_____

2. Does your child have allergies to medicine, food, latex or insect bites? [ ] No [ ] Yes
   Allergic to what:_____What happens:_____
   Treatment:_____
3. Has your child had any illness since school ended last June? [ ] No [ ] Yes
   Type of illness with date(s):_____
4. Has your child had surgery in the last 12 months? [ ] No [ ] Yes
   Type of surgery with date(s):_____
5. Has your child received any immunizations in the last 12 months? [ ] No [ ] Yes
   List immunizations with date(s):_____
6. Is your child being treated or evaluated for any health conditions? [ ] No [ ] Yes
   List condition(s):_____
7. Is your child on any medications or treatments? [ ] No [ ] Yes
   Name of medication(s) or treatment(s):_____
   Does your child need medication during school hours? [ ] No [ ] Yes
   ** IF YES, YOU MUST CONTACT THE SCHOOL NURSE AND MAKE THE NECESSARY ARRANGEMENTS
8. Has your child ever been examined by an eye doctor? [ ] No [ ] Yes
   Date of last exam:_____ [ ] normal [ ] glasses/contacts prescribed
9. Has your child had any emotional upsets (recent move, death, separation, divorce) in the last 12 months?
   Please list:_____ [ ] No [ ] Yes
10. Has your child had any injuries or fractures in the last 12 months? [ ] No [ ] Yes
    Type of injury/fracture: _____ List any limitations due to injury:_____
11. What was the date of your child's last dental exam?_____Concerns?_____
    Does your child have braces? [ ] No [ ] Yes
12. What was the date of your child's last physical examination?_____

Thank you for helping to keep your child's School Health Record up to date.
If there are any changes during the school year, please inform the school nurse of these changes.

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