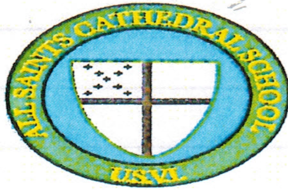

ALL SAINTS CATHEDRAL SCHOOL
HEALTH HISTORY FORM

Student's name Gr____ School year____	Sex ◯male ◯Female	Date of birth / /
Parent/Guardian with whom child lives with	Alt. Emergency No.	Child's Physician
Name		
Contact #		
Alt. Contact#		
Email		

Student Health Conditions

☐ **YES,** my child receives regular medical/health care for the following conditions: ☐ **NO** medical conditions

☐ Allergies	☐ Diabetes	☐ Seizure disorder
☐ Asthma	☐ Depression	☐ Sickle cell anemia
☐ ADD/ADHD	☐ Ear problem/hearing difficulty	☐ Skin conditions
☐ Autism	☐ Emotional concerns	☐ Speech problems
☐ Behavior concerns	☐ Headaches	☐ Traumatic brain injury
☐ Birth/congenital malformations	☐ Heart problems	☐ Vision problems (glasses, contacts)
☐ Bone/muscle/joint problems	☐ Hemophilia	☐ Other____________
☐ Blood problems	☐ Juvenile arthritis	☐ Other____________
☐ Bowel/bladder problems	☐ Lead poisoning	☐ Other____________
☐ Cancer	☐ Migraines	☐ Other____________
☐ Cystic fibrosis	☐ Neuromuscular disorder	☐ Other____________

Please explain any conditions above or any reasons for hospitalizations.

____

Please indicate any allergies your child may have.

Allergy type	Reaction	School restrictions or recommended actions
☐ Bee/Insect		
☐ Food		
☐ Medication		
☐ Other		