St. Michael Catholic School
Health Services
Student Health History

Student's Full Name: _____Date of Birth *(mm/dd/yyyy)*: _____

New Student: _____ Returning Student: _____ Grade: _____

Does the student have any of the following health conditions?

Health Conditions			**Comments:** *Include all dates, symptoms and treatment as they apply*
ADD/ADHD *	**Yes**	**No**	
Allergies (food, medication, insects, etc.) *	**Yes**	**No**	
Asthma *	**Yes**	**No**	
Cancer(Type)*	**Yes**	**No**	
Diabetes(type 1 or 2) *	**Yes**	**No**	
Heart Issues*	**Yes**	**No**	
Head Injury/Concussion	**Yes**	**No**	
Kidney/Urinary Issues	**Yes**	**No**	
Eye/Vision Issues*	**Yes**	**No**	
Hearing Issues*	**Yes**	**No**	
Neurological Issues/Seizures*	**Yes**	**No**	
Bleeding Disorders*	**Yes**	**No**	
Autism	**Yes**	**No**	
Physical Handicaps	**Yes**	**No**	
Other Health Issues	**Yes**	**No**	

Additional Form Required - Physician's Order Required

COMMENTS AND/OR PROCEDURES:

Does the student take any medication on a regular basis? **Yes: ____** ***(Please list below)*** **No: ____**

Medication	**Dose**	**Time(s) Medication is Administered**

Note: ***If your child will be taking medication at school, whether prescription or over-counter, please complete the school medication form.***

Does your child have any restrictions at school: Yes _____ No_____ ***(If yes, Physician's note is required)***

I understand that I may be required to furnish a doctor's statement verifying the above information. I also understand that this information is confidential and is being furnished for the exclusive use of St. Michael Catholic School Health Services and will not be released to any non- school personal without my written consent.

Parent/Guardian Name: _____
(Please Print)

Parent/Guardian Signature: _____ Date: _____