SOUTHERN LEHIGH SCHOOL DISTRICT

SAINT MICHAEL THE ARCHANGEL – COOPERSBURG/COLESVILLE

HEALTH HISTORY SHEET

STUDENT NAME_____ **BIRTHDATE**_____ **GENDER M / F**

ADDRESS

_____

_____

Mother's First/Last Name _____ **PHONE NUMBER** _____

Father's First/Last Name _____ **PHONE NUMBER** _____

EMERGENCY CONTACT NAME _____ **PHONE NUMBER** _____

EMERGENCY CONTACT NAME _____ **PHONE NUMBER** _____

FAMILY DOCTOR NAME _____ **PHONE NUMBER** _____

PREFERRED HOSPITAL

_____

SCHOOL DISTRICT IN WHICH STUDENT RESIDES _____

DOES YOUR CHILD HAVE OR HAD ANY OF THE FOLLOWING? Give dates and details.

	YES	NO	IF YES, PLEASE EXPLAIN
ASTHMA	☐	☐	
Uses Inhaler	☐	☐	
ALLERGIES	☐	☐	
FOODS	☐	☐	
INSECT STINGS	☐	☐	
MEDICATIONS	☐	☐	
OTHER (specify – ie environmental)	☐	☐	
Was your child prescribed an Epi Pen for their allergy?	☐	☐	

ADD/ADHD	☐	☐
ARTHRITIS/RHEUMATIC DISEASE	☐	☐
AUTISM SPECTRUM DISORDER	☐	☐
BLOOD DISORDER/COOLEY'S ANEMIA	☐	☐
CANCER	☐	☐
CARDIOVASCULAR DISORDER	☐	☐
CEREBRAL PALSY	☐	☐
CONCUSSIONS/HISTORY OF	☐	☐
CYSTIC FIBROSIS	☐	☐
DIABETES (TYPE I OR II)	☐	☐
EMOTIONAL PROBLEMS	☐	☐
EPILEPSY/OTHER SEIZURE DISORDERS	☐	☐
GASTROINTESTINAL DISORDER	☐	☐
HEARING PROBLEMS	☐	☐
MUSCULOSKELETAL DISORDER	☐	☐
NEUROLOGICAL DISORDER	☐	☐
RENAL DISORDER	☐	☐
RESPIRATORY DISORDER	☐	☐
SICKLE CELL DISEASE	☐	☐

_____

SPINAL BIFIDA ☐ ☐

_____

SPEECH PROBLEMS ☐ ☐

_____

SURGERIES, Previous ☐ ☐

_____

TOURETTE'S SYNDROME ☐ ☐

_____

VISION PROBLEMS ☐ ☐

_____

OTHER-PLEASE SPECIFY

_____

_____

Is your child currently under medical treatment? YES NO

If yes, please explain

_____

Does your child currently take any medications? YES NO

If yes, please list medication(s) and dose

_____

Does your child require special consideration in gym class?

_____

Please list any other information you feel is important for the school nurse to know

_____

_____

_____

Parent/Guardian Signature _____ **Date** _____