SAINT LEO THE GREAT CATHOLIC SCHOOL
HEALTH HISTORY

Student's Name: ____ ____________

Last | First | Date of Birth | Grade

	Yes	No	If Yes, please explain
Allergies...	☐	☐	

(*please circle all that apply*)

Bee Peanut Tree Nuts Egg Milk/Dairy Shellfish Latex Environmental Seasonal

Other, including Drug Allergies (*please specify*): ____

Emergency medication needed, such as Epinephrine (Epi-pen)? ______________________________

Asthma...	☐	☐	Does the student use inhaler? ____________
Seizure Disorder..............................	☐	☐	Date of last seizure? ____________________

Emergency Seizure Medication needed/which med? ____

Diabetes...	☐	☐	Type 1 Type 2

Medication: ____

Lactose Intolerance..........................	☐	☐	______________________________________
Cardiac...	☐	☐	______________________________________
Gastrointestinal Disorder....................	☐	☐	______________________________________
Hearing Disorder..............................	☐	☐	______________________________________
Hypertension..................................	☐	☐	______________________________________
Neuromuscular Disorder.....................	☐	☐	______________________________________
Orthopedic Condition........................	☐	☐	______________________________________
Skin Disorder..................................	☐	☐	______________________________________
Vision Disorder................................	☐	☐	______________________________________
Other (Specify).	☐	☐	______________________________________

List all Medications and Doses: ____

____

Vision: Glasses Contacts Other: ____

Hearing Loss: Yes No Hearing Aids: Yes No

(over)

Emotional / Behavioral History (Note special problems / age of occurrence):

☐Anger ☐Depression

☐Wetting/Soiling ☐Eating Disorder

☐Other (Specify) ____

Learning Disability ☐Yes ☐No (If Yes, explain) ____

Speech Difficulty ☐Yes ☐No (If Yes, explain)____

ANNUAL HEALTH UPDATE:

Serious illness, injury, hospitalization or operation during the past year? Yes No

Describe: ____

Is your child still under treatment: Yes No

Restricted from physical activity: (Written Restrictions signed by a doctor required) Yes No

Describe: ____

Special diet and/or have a specific food restriction? Yes No

Describe: ____

Recent changes we should be aware of? (Separation, Divorce, Illness, Death, etc.) Yes No

Describe: ____

☑ I give consent to the release of information for immunizations, physicals, and dental exams from my healthcare provider.

☑ I consent to the release of health information (i.e. allergies, asthma, seizures, etc.) to school personnel on a need to know basis.

Signature of Parent/Guardian: ________________________________**Date:** ______________