

**St. Gabriel Consolidated School
Student Health History**

TO BE COMPLETED BY PARENT/GUARDIAN

Child's Name	Gender <input type="checkbox"/> Male <input type="checkbox"/> Female	Age	Birthdate
Ethnicity <input type="checkbox"/> Caucasian <input type="checkbox"/> African American <input type="checkbox"/> Hispanic <input type="checkbox"/> Asian American <input type="checkbox"/> Other			
Parent/Guardian:			
Parent/Guardian Address:		City:	State: Zip Code:
Home Phone #		Work Phone #(s)	
Cell Phone #(s)			

Disease/Illness History - PLEASE CHECK ANY THAT THIS CHILD HAS HAD:

ADD/ADHD	<input type="checkbox"/>	Cystic Fibrosis	<input type="checkbox"/>	Meningitis	<input type="checkbox"/>
Anemia	<input type="checkbox"/>	Diabetes	<input type="checkbox"/>	Migraines	<input type="checkbox"/>
Arthritis	<input type="checkbox"/>	Eating Problems	<input type="checkbox"/>	Rheumatic Fever	<input type="checkbox"/>
Asthma	<input type="checkbox"/>	Emotional Problems	<input type="checkbox"/>	Scoliosis	<input type="checkbox"/>
Behavior Problems	<input type="checkbox"/>	Encephalitis	<input type="checkbox"/>	Seizures/Epilepsy	<input type="checkbox"/>
Cancer	<input type="checkbox"/>	Eye Problems	<input type="checkbox"/>	Skin Conditions	<input type="checkbox"/>
Chicken Pox	<input type="checkbox"/>	Headaches	<input type="checkbox"/>	Sickle Cell	<input type="checkbox"/>
Chronic Constipation	<input type="checkbox"/>	Heart Disease	<input type="checkbox"/>	Tics/Twitches	<input type="checkbox"/>
Chronic Diarrhea	<input type="checkbox"/>	Hepatitis	<input type="checkbox"/>	Toothaches	<input type="checkbox"/>
Chronic Ear Infections	<input type="checkbox"/>	Kidney Disease	<input type="checkbox"/>	Urinary Tract Infections	<input type="checkbox"/>
Other	<input type="checkbox"/>	Other	<input type="checkbox"/>	Other	<input type="checkbox"/>

Explain those that were checked above:

Allergies

Please list and describe any allergies and/or reactions:

Medication/Drug Allergy	Reactions/Symptoms
Food Allergy	Reactions/Symptoms
Plant/Animal Allergy	Reactions/Symptoms
Recommended treatment of allergy is severe:	

OVER

Injuries, Illnesses & Hospitalizations/Surgeries – Please include age of child at the time

Injuries/Illnesses/Hospitalizations	Age	If hospitalized, please explain:

Physical Handicaps – List below and explain:

Speech and Hearing

- Has child ever received speech therapy? Yes No If Yes, when _____
- Has family ever noticed a reduction of hearing? Yes No If Yes, when _____
- Has child had treatment for an ear condition? Yes No If Yes, when _____
- Has child ever worn a hearing aid? Yes No If Yes, when _____
- Has child ever had P.E. tubes? Yes No If Yes, when _____

Eyes/Vision

- Does child ever wear glasses? Yes No
- Does child wear contacts? Yes No
- Has child had eye surgery? Yes No If Yes, when and why

I (do / do not) give permission for this information to be shared with school personnel as needed for the benefit of my child’s health or educational needs.

PARENT SIGNATURE _____ **DATE** _____