St. Gabriel Consolidated School
Student Health History

TO BE COMPLETED BY PARENT/GUARDIAN at the time of registration to make sure we accommodate your child.

Child's Name	Gender ☐ Male ☐ Female	Age	Birthdate
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 A HISTORY OF:

Anemia		Diabetes		Migraines	
Arthritis		Eating Problems		Rheumatic Fever	
Asthma		Encephalitis		Scoliosis	
Cancer		Eye Problems		Seizures/Epilepsy	
Chicken Pox		Headaches		Skin Conditions	
Chronic Constipation		Heart Disease		Sickle Cell	
Chronic Diarrhea		Hepatitis		Tics/Twitches	
Chronic Ear Infections		Kidney Disease		Toothaches	
Cystic Fibrosis		Meningitis		Urinary Tract Infections	

Describe those that were checked above or any other conditions:

_____
_____
_____

History of Emotional-Behavioral Disorder – please include any specific details below:

_____
_____
_____
_____

History of ADD/ADHD - _____
_____

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 if 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 wear glasses? □ Yes □ No
Does child wear contacts? □ Yes □ No
Has child had eye surgery? □ Yes □ No If Yes, when and why
_____
_____

OT/PT

Has child ever received occupation or physical therapy? □ 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*** _____