Health History

St Peter School
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www.stpschool.org

Phone: 732-892-1260
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Student Name: _____Date of Birth_____

Past Medical History

HOSPITALIZATIONS

Has your child ever been hospitalized? _____
If yes please list dates, hospital and reason for hospitalization

_____ _____ _____
_____ _____ _____
_____ _____ _____

CHILDHOOD ILLNESSES

Has your child had any of the following?

Measles (Rubeola)_____	YES	NO	Mumps_____	YES	NO
German Measles (Rubella) __	YES	NO	Pneumonia_____	YES	NO
Meningitis_____	YES	NO	Diabetes_____	YES	NO
Chicken Pox_____	YES	NO	Streptococcal infections_____	YES	NO
Scarlet Fever_____	YES	NO	High Fever		
Rheumatic Fever_____	YES	NO	(104˚ for 2 or more days) _____	YES	NO

OTHER ILLNESSES AND CONDITIONS

Has you child ever had any important illnesses for which he/she was not hospitalized?_____NO YES

If **YES**, list dates, type of illness and treatment.

_____ _____ _____
_____ _____ _____
_____ _____ _____

ALLERGIES

Has your child ever had problems with the following?

Eczema_____	YES	NO	Nasal or Eye Allergies_____	YES	NO
Food Allergy_____	YES*	NO	Severe reaction to insect stings_	YES	NO
If yes please describe_____			If yes please describe_____		
_____			_____		
Asthma _____	YES*	NO	_____		
If YES please complete a School Asthma Record			Hayfever_____	YES	NO

(OVER)

PRESENT MEDICAL HISTORY

GENERAL

Does you child have any physical restrictions?_____YES NO

Does you child take ANY medications regularly?_____YES NO

IF YES, please list:

_____

_____

_____

_____

EARS, NOSE and THROAT

Has your child had two to three episodes of ear problems in a year?_____YES NO

Does you child have trouble hearing?_____YES NO

Does your child have tubes in his/her ears?_____YES NO

Has you child had two or more throat infections in a year?_____YES NO

Does you child have frequent nosebleeds?_____YES* NO

If YES how do you control them?_____

Does your child get swollen glands frequently?_____YES NO

RESPIRATORY AND CARDIAC

Has your child had four to six colds in a year?_____YES NO

Does your child get a severe cough with colds?_____YES NO

Does you child have trouble getting rid of a cold?_____YES NO

Does you child have asthma or wheezing problems?_____YES NO

Does your child have any cardiac history including heart murmur?_____YES* NO

If YES please describe_____

GASTROINTESTINAL

Does your child have stomachaches?_____YES NO

Does your child have trouble with food disagreeing with him/her?_____YES NO

COMMENTS:

_____

_____

_____

_____

_____

_____

_____

_____

Signed_____Date_____