✝1883~Our Lady Help of Christians School~2019✝

HEALTH HISTORY 2018-2019

Student's Name _____ Birth Date_____ Grade_____

****PRENATAL & DEVELOPMENTAL HISTORY****

Did the mother have any unusual problems/ illnesses during the pregnancy or the birth, such as breech, forceps or cesarean delivery? Yes _____ No _____ If yes, explain briefly: _____

_____

Was this infant born _____full term _____ early (premature) _____ late?

Did the infant have any sickness or problem after birth, such as yellow-jaundice, blue spell or convulsions?

__Yes ___ No If yes, explain briefly: _____

Please give the approximate age at which the child: Walked___ Said words ____ Toilet trained ____
How does this child's development compare to other children (siblings & peers/playmates)?
_____ about the same _____slower _____faster

~HEALTH HISTORY~

Has this child had: Check all that apply; give approximate ages:

_____ Anemia _____ Fainting Spells _____High Fevers _____Asthma
_____Headaches _____ Dental Problems _____Chicken Pox _____Heart Disease
_____Lead poisoning _____Diabetes _____Nose Bleeds
_____ Poor Hearing _____Eye Problems (poor vision or crossed eyes)
_____ Tooth-aches _____Wears glasses or contact
_____ Sore Throats (infections) _____Sickle Cell Anemia

Does the child have any allergies (medications, foods, pollen, animals)? ___Yes ___No If yes, what are these?

Has this child had any other illnesses? _____
Has this child had any condition which required emergency treatment or hospitalization? ___Yes ____No
If yes, explain briefly: _____
Is this child presently under a physician's care? ___Yes _____No Reason for the care:_____
Doctor's Name: _____ Address_____
Is this child taking any medication(s)? ___Yes ___ No If yes, name of medication(s):_____
_____
Does this child have any medical or physical problem(s)? ____ Yes ____ No If yes, explain briefly:_____
_____
Does any relative or household member have any medical problems such as tuberculosis or other chronic conditions? ___Yes ___ No If yes, explain:_____
_____

If you have any concern about your child's health, please contact our school nurse, you may call her at (973) 677-1546 during school hours.

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HEALTH CLINIC EMERGENCY INFORMATION

Student's Name: _____ **Grade:** _____ **D.O.B**___/_____/___

Address: _____

Street **Town/State** **Zip Code**

Parent/Legal Guardian: _____

Mother

Place of Employment:_____

Phone # (_____)_____-_____ (circle) Home or Cell

Phone # (_____)_____-_____ (circle) Home or Cell

Parent/Legal Guardian: _____

Mother

Place of Employment:_____

Phone # (_____)_____-_____ (circle) Home or Cell

Phone# (_____)_____-_____ (circle) Home or Cell

If you CANNOT be reached, please list the names of two(2) person (relative or friends) who will assume temporary care of child/ren until you can be available: (These people should be in the immediate area of the school.)

Name_____ **Phone #: (_____) _____-_____**

Relationship to Child: _____

Name_____ **Phone #: (_____) _____-_____**

Relationship to Child: _____

List any present conditions or allergies which should be known to the school office or nurse. _____

_____

Physician's Name (Child): _____

Office Address:_____ **Phone #: (_____) _____- _____**

PLEASE READ THE FOLLOWING STATEMENT

(SIGN TO ACNOWLEGE THAT YOU UNDERSTAND AND AGREE WITH THE STATEMENT.)

In the case of an emergency situation, such as an accident or serious illness, I understand that the school shall attempt to contact me. If I cannot be reached, I authorize the school to contact the doctor listed above and follow the doctor's directions. If the doctor cannot be contacted, I authorize the school to take whatever steps seem necessary for my child.

I certify that the above information is correct and accurate to the best of my knowledge. I will contact the School Office and Health Office within twenty- four hours if there are any changes in the above information.

_____ _____ _____

Parent/Legal Guardian Signature **Print Name** **Date**