St. Joseph School
York, PA • sjy.org

HEALTH HISTORY

To Parent or Guardian: Please complete this form. This information will become a part of your child's health record. It will help the school meet your child's educational needs.

PLEASE ATTACH A COPY OF YOUR CHILD'S IMMUNIZATION RECORD

Child's Name_____
LAST FIRST MIDDLE

Address _____

Birth Date_____Student is being enrolled in grade _____

Father's name_____Mother's name _____

Person with whom child resides (if other than parent) _____

Name / address of last school attended _____

CHILD'S HEALTH HISTORY

Please check any of the following health problems your child has / had. Use back of paper, if needed, for additional information.

- ☐ Asthma
- ☐ Chicken Pox (date_____)
- ☐ Heart Disease
- ☐ Hepatitis
- ☐ TB
- ☐ Vision Problems
- ☐ Hearing Problems
- ☐ Seizure Disorder
- ☐ Cancer
- ☐ Diabetes
- ☐ HIV / AIDS
- ☐ Psychiatric Disorder
- ☐ Developmental Problems
- ☐ Learning Problems
- ☐ Other: _____

Health Questionnaire		Please Check Y/N
1.	Was your child a full term baby?	☐ Yes ☐ No
2.	What was your child's birth weight? _____lbs. _____oz.	
3.	Did your child have problems at birth?	☐ Yes ☐ No
4.	Has your child had any surgery?	☐ Yes ☐ No
	If so, what surgery and when was it done? _____	

(OVER)

5. Is your child under medical care now for a health problem? ☐ Yes ☐ No

If so, what is the health problem _____

6. Is your child taking medication(s) at this time? ☐ Yes ☐ No

Name of medication(s) _____

Reason(s) _____

7. Does your child need to take medication at school? ☐ Yes ☐ No

If "yes", a school medication order form must be kept on file at school.

8. Is your child allergic to any food, medications, insect bites, etc.? ☐ Yes ☐ No

Describe allergic reaction_____

9. Does your child need a special diet? ☐ Yes ☐ No

If so, what type? _____

10. Is there a family history of physical or emotional illness that might affect your child? ☐ Yes ☐ No

If "yes", please give information on back of this form.

11. Is your child covered by health insurance? ☐ Yes ☐ No

Name of Physician_____Phone _____

Name of Dentist_____Phone _____

All physician orders for any medical conditions must be submitted by June 1st of the enrolling year.

Signature of Parent/Guardian_____Date _____