ST. JOSEPH SCHOOL, Kennewick, WA

MEDICAL HISTORY FORM

Student Name ______________________ Age __________ Date of Birth __________

Mother's Telephone# ____________________ Mother's Cell# ____________________

Father's Telephone# ____________________ Father's Cell# ____________________

Parent/Guardian (*Please print*) ______________________________

HISTORY

		YES	NO
1.	Is your student under a doctor's care now?	______	______
2.	Are any medications or drugs being taken now?	______	______
3.	Any Allergies to : Bee Stings	______	______
	Asthma	______	______
	Medications	______	______
4.	Heart: Murmur of rheumatic fever?	______	______
	Has anyone in the family, under the age of 50 died of heart disease?	______	______
5.	Are there vision problems?	______	______
	Glasses	______	______
	Contact Lenses	______	______
6.	Are there or have there been problems with:	______	______
	Hearing	______	______
	Kidneys	______	______
	Testicles	______	______
	Hernias	______	______
7.	Has your child had any major medical illnesses?	______	______
	Seizures	______	______
	Diabetes	______	______
	Arthritis	______	______
8.	Have there been any operations or surgeries?	______	______
9.	History of head trauma or repeated concussions?	______	______
10.	Been in the hospital in the past year?	______	______
11.	What was the date of last tetanus booster?		

Please explain any "Yes" answers on the above questions. Any further instructions or treatment required by the school personnel?

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Signature of Parent/Guardian ______________________ Date ______________