Holy Trinity School, 510 Church Ave., Casco, WI 54205 (920) 837-7531

STUDENT HEALTH HISTORY

Child's Name: _____ Age: _____ Date of Birth: _____

Address: _____ Phone: _____

Parent's Names: _____

Names of Brothers and Sisters:	Date of Births:
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Please check if your child has had any of the following conditions:

_____ Asthma
_____ Attention Deficit
_____ Convulsions / Epilepsy / Seizure Disorder
_____ Chickenpox
_____ Diabetes
_____ Emotional / Psychiatric Disorder
_____ Fainting Spells
_____ Heart Condition
_____ High Blood Pressure
_____ Kidney Problems
_____ Measles / Mumps
_____ Neck / Back Injury
_____ Respiratory Condition
_____ Rheumatic Fever
_____ Tonsillitis
_____ Serious Injury (Describe: _____)
_____ Surgery (Describe: _____)
_____ Hearing Problems
_____ Vision Problems (Does your child wear glasses / contacts _____yes _____no)
_____ Other: (Please list: _____)

Allergies _____yes _____no (Example: bee stings, food allergies, drug allergies, etc.)
Please list allergies: _____
_____
_____

Medical Alert Information - Other than the allergies listed above, is your child under any medical supervision or on any medication for a health problem? _____yes _____no
If yes, please describe and list medications: _____
_____
_____

Parent's/Guardian's Signatures: _____
Date Signed: _____

Please list anything else that we should know about your child's medical history on the back side of this form.