

HEALTH HISTORY

Assessments dated within 6 months of school are requested.



Immunization Card

A completed immunization card must be submitted prior to beginning of school year.

Child's Health Card No. _____

Expiry Date: _____

First Name:	Middle Name:	Last Name:
Birthdate:	Height:	Weight:

Please briefly comment on your child's overall health:

If your child is not able to participate in certain athletic and school activities, please outline:

Has your child ever had his/her eyes tested by a vision specialist: Yes No

Explain Result:

Has your child ever has his/her hearing tested by a specialist: Yes No

Explain Result:

Does your child have frequent: Colds Tonsilitis Stomach Aches High Fevers

Does your child have any allergies:

Briefly explain child's reaction to any of these allergies and any medication taken for these:

Does your child have a diagnosed condition:

Does your child have any congenital problems/issues:

Is your child receiving a medication program:

EMERGENCY INFORMATION Please give the name of someone, other than the parent or guardian, who can be contacted in case of an emergency:

Name: _____ Relationship: _____

Emergency Phone Numbers: _____

Name of Physician: _____ Address: _____ Telephone: _____

Thank you for answering these questions. We hope this will better enable us to meet your child's needs and make his/her days at St. Jude's Academy pleasant and productive.

Signature of Parent or Guardian: _____ Date: _____

