St. James Academy Health Suite

Annual Student Medical History

To be completed annually by a parent or guardian

Student's Name:______________________________________ Date of Birth:_______________ Grade: ___

Is your child under a doctor's care for any chronic illness or disorder? Yes ____ No ____

If yes, please explain: ____

During the last 12 months:

Any hospitalizations or surgeries? Yes ____ No ____

If yes, please explain: ____

Any injuries requiring medical attention? Yes ____ No ____

If yes, please explain: ____

Does your child take any daily or long term medication? Yes ____ No ____

If yes, please list: ____

Does your child have any allergies to medication(s)? Yes ____ No ____

If yes, please list: ____

Does your child have any allergies to foods or insect stings? Yes ____ No ____

If yes, please list briefly here and request an Emergency Health Form from the School Nurse.

____

Does your child wear any dental appliance or any prosthesis? Yes ____ No ____

If yes, please describe: ____

Does your child wear eyeglasses or contact lenses? Yes ____ No ____

Does your child receive speech, physical or occupational therapy? Yes ____ No ____

Are there any issues that you would like to discuss with the school nurse? Yes ____ No ____

May the School Nurse share this information with your child's teacher(s)? Yes ____ No ____

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Signature of Parent/Guardian Date