St. Gabriel School

HEALTH HISTORY
(new students)

FAMILY DATA

Child's Name_____ Date of Birth_____

Physician_____ Dentist_____ Hospital_____

Mother's Name_____ Home Phone_____

Home Address_____

Father 's Name_____ Home Phone_____

Home Address_____

MEDICAL HISTORY

Has your child had any of the following:

Asthma	Yes____	No_____	Don't Know _____
Convulsions	Yes____	No_____	Don't Know _____
Heart Condition	Yes____	No_____	Don't Know _____
Rheumatic Fever	Yes____	No_____	Don't Know _____
Sickle Cell History	Yes____	No_____	Don't Know _____
Chicken Pox	Yes____	No_____	Don't Know _____
Frequent Ear Infection	Yes____	No_____	Don't Know _____

Is your child on long term medication? If yes, please explain:_____

Does your child have allergies? Insect bite_____ Bee stings_____ Food _____ Medication____
Other:_____

Has your child ever had surgery? If yes, Date and type_____

Has your child been seen by a specialist? If yes, please explain:_____

_____ _____

Has your child had any significant illness or injuries we should be aware of? If yes, please explain:____

Is there anything you think we should know about your child? If yes, please explain:_____

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