STUDENT HEALTH HISTORY

1 STUDENT INFORMATION

NAME OF STUDENT

STUDENT'S PRIMARY HEALTHCARE PROVIDER | PHONE

STUDENT'S DENTIST | PHONE

STUDENT'S HEALTHCARE INSURANCE PROVIDER

2 HEALTH QUESTIONNAIRE

		YES	NO
1. Does the student have allergies?	To Medication?	❑	❑
	To Food?	❑	❑
2. Does the student take any medications?		❑	❑
3. Does the student have any special needs the school should be aware of?		❑	❑
4. Has the student had chickenpox?		❑	❑
5. Does your family have any major health problems?		❑	❑
6. Has the student had a hearing test?		❑	❑
Does the student have a hearing problem?		❑	❑
7. Has the student had a vision test?		❑	❑
Does the student have a vision problem?		❑	❑
Does the student wear glasses or corrective lenses?		❑	❑
8. Does the student have a speech problem?		❑	❑
If yes, is the student receiving speech therapy?		❑	❑

9. Please check any of the following illnesses or conditions the student has had.

- ❑ ACCIDENTS
- ❑ ALLERGIES
- ❑ ANEMIA
- ❑ ASTHMA
- ❑ BEHAVIOR PROBLEMS
- ❑ BIRTH DEFECT
- ❑ BONE/JOINT ISSUES
- ❑ BOWEL PROBLEMS
- ❑ DENTAL ISSUES
- ❑ DIABETES
- ❑ EAR/THROAT ISSUES
- ❑ G6PD
- ❑ HEART ISSUES
- ❑ HEADACHES
- ❑ HOSPITALIZATIONS
- ❑ KIDNEY/URINARY
- ❑ LEARNING DISABILITY
- ❑ LEAD POISONING
- ❑ MENSTRUAL ISSUES
- ❑ RESPIRATORY PROBLEMS
- ❑ RHEUMATIC FEVER
- ❑ SEIZURES
- ❑ SICKLE CELL
- ❑ SKIN PROBLEMS
- ❑ TB
- ❑ WEIGHT ISSUES

IF YOU CHOSE "YES" TO ANY QUESTIONS OR CHECKED ITEMS IN #9, PLEASE EXPLAIN HERE:

If necessary, continue remarks on reverse side.

PARENT/GUARDIAN SIGNATURE | PRINT NAME | DATE

CATHEDRAL
7-12 HIGH SCHOOL • BOSTON

PLEASE RETURN THIS COMPLETED FORM TO:

MAIL: Cathedral 7-12 High School, *Health Office*, 74 Union Park St., Boston MA 02118

FAX: (617) 542-1745