Mount Carmel Area School District

Child's Name:_____ Grade:_____ Age:_____

Health History

Does the child have any allergies to medications/ food/ environment? Yes or No
To what?_____
Reaction:_____

Has the child ever had any of the following illnesses/problems?

	Yes	No	
"Red" Measles	☐	☐	If Yes- Age_____
Whooping Cough	☐	☐	If Yes- Age_____
Rheumatic Fever	☐	☐	If Yes- Age_____
German or "3 day" Measles	☐	☐	If Yes- Age_____
Pneumonia	☐	☐	If Yes- Age_____
Tuberculosis	☐	☐	If Yes- Age_____
6 colds or throat infections within a year	☐	☐	
tonsils been removed	☐	☐	If Yes- Age_____
Trouble with ears, hearing or frequent ear infections	☐	☐	Please Describe_____
Tubes in child's ears	☐	☐	If Yes- Age_____
Trouble with eyes or seeing	☐	☐	
Child wears glasses	☐	☐	
Will require special seating in classroom	☐	☐	
Had a fainting spell	☐	☐	If Yes- Age_____
Frequent headaches	☐	☐	
Heart Murmur	☐	☐	Restrictions?_____
Frequent Diarrhea	☐	☐	
Constipation	☐	☐	
Worms/Parasites	☐	☐	If Yes- Age_____
Blood in child's bowel movements	☐	☐	
Yellow Jaundice/ Trouble with liver	☐	☐	If Yes- Age_____
Frequently complain of Bellyaches	☐	☐	
Bladder/Kidney Problems	☐	☐	Please Describe_____
Skin Problems	☐	☐	
Asthma/Wheezing	☐	☐	
Trouble breathing through the nose	☐	☐	
Does the child snore	☐	☐	
Trouble sleeping	☐	☐	
Pain in Arms or Legs	☐	☐	Please Describe_____
Swelling of Joints or Limping	☐	☐	Please Describe_____
Bleeding Disorders	☐	☐	Please Describe_____
Lead Poisoning	☐	☐	Please Describe_____
Concussion or other head injury	☐	☐	Please Describe_____
Diabetes	☐	☐	If yes- Age _____
Allergy or Reaction to Medications	☐	☐	Please Describe_____
Reaction to Immunizations	☐	☐	Please Describe_____
Food allergies or foods that do not agree with child	☐	☐	Please Describe_____
Seizures	☐	☐	Please Describe_____

SEE OTHER SIDE

Speech Problems	☐	☐	Please Describe_____
Receiving Speech Therapy	☐	☐	
Diagnosed with ADD or ADHD	☐	☐	If yes- Age____
	Medications:_____		
Any Serious Illnesses	☐	☐	Please Describe_____
Hospitalizations	☐	☐	Please Describe_____
Operations	☐	☐	Please Describe_____
Accidents	☐	☐	Please Describe_____
Broken Bones	☐	☐	Please Describe_____
Trouble with teeth	☐	☐	Please Describe_____
Ever been seen by a dentist	☐	☐	
Name of Dentist:_____			
Is the child under care of a physician now?	For What?_____		
Other Special Health Needs of the Child?	_____		
	_____		
Will the child need to take a medication during school hours?	☐	☐	
_____	What medications:_____		

Please Circle Any of the Following Diseases that the child's parents, brothers, sisters, grandparents, aunts, uncles or other family member has had in the past

Allergy	Diabetes
Anemia	Seizures/ Epilepsy
Asthma	Heart Disease/ Heart Murmur
Arthritis	High Blood Pressure
ADD/ADHD	Blood Disorder
Cancer	Bleeding Disorder
Drug Addiction	Other Inherited Family Disease:
Alcohol Addiction	_____
Gastrointestinal Disorder	_____
Seizures	_____
Sickle Cell Anemia	_____
Vision or Hearing Problems	_____
Kidney Disorder	_____
Migraine headaches	_____

Signature of Parent/Guardian:_____ Date:_____