

Christ Lutheran School Student Health History

Please complete one Student Health History for EACH child you are registering.

Date: _____

Name of Student: _____ Date of birth: _____

Doctor's Name: _____ Phone: _____
(First) (Last)

Dentist's Name: _____ Phone: _____

Please indicate with an "X" if your child has had any of the following diseases, allergies, conditions or symptoms.

Allergy:

Asthma _____
Eczema _____
Hay Fever _____
Medication _____

Operations (type & date):

Disease (date):

Chickenpox _____
Measles _____
Mumps _____
Rheumatic Fever _____
Scarlet Fever _____
Tuberculosis _____
Others _____

Other Serious Illnesses:

Upper Respiratory:

Cough _____
Frequent Colds _____
Sore Throat _____
Ear Infection _____

Symptoms Occurring Frequently:

Fainting _____
Fatigue _____
Growing Pains _____
Headaches _____
Nosebleeds _____

Others:

Heart Disease _____
Hernia _____
Kidney Infection _____

Please answer the following questions: (if yes, please explain)

Does your child have a speech impediment? _____
Does your child have a hearing problem? _____
Does your child have vision difficulty? _____
Does your child have a physical handicap? _____
Is your child diabetic? _____
Is your child taking medication for A.D.D.? _____

Please list the name of any prescription medication your child takes on a daily basis:

IF ANY MEDICATION NEEDS TO BE ADMINISTERED AT SCHOOL, PLEASE COMPLETE THE NECESSARY FORMS AVAILABLE IN THE SCHOOL OFFICE.

Comments about your child's health: _____

Father/Guardian Signature

Date

Mother/Guardian Signature

Date