MOST BLESSED SACRAMENT CATHOLIC SCHOOL
STUDENT HEALTH HISTORY UPDATE

Please complete and return to the school nurse. This will assist in keeping an up-to-date Student Health Record on file. This information will be shared with staff and administration on a NEED TO KNOW basis unless you notify us otherwise.

DATE: _____ SEX: M _____ F_____ GRADE: _____
NAME: _____ BIRTHDATE: _____
SCHOOL ATTENDED LAST YEAR: [ ] MBS [ ] Other_____

1. Please check if your child has been diagnosed, has a history of, or has any difficulty with the following conditions. Give additional information under comments:

[ ] ADD/ADHD
[ ] Asthma
[ ] Behavior Problems
[ ] Bleeding Disorder
[ ] Body Piercing/Tatoo
[ ] Bowel/Bladder
[ ] Chicken Pox
[ ] Diabetes
[ ] Emotional
[ ] Epilepsy/Seizures
[ ] Fractures (Specify)
[ ] Frequent Ear Infections
[ ] German Measles
[ ] Hearing Difficulty
[ ] Hypertension (High BP)
[ ] Infections
[ ] Lyme Disease
[ ] Migraine Headaches
[ ] Measles
[ ] Menstruation _____
Date of onset
[ ] Mononucleosis
[ ] Mumps
[ ] Pneumonia
[ ] Rheumatic Fever
[ ] Scarlet Fever
[ ] Speech Difficulty
[ ] Strep Throat
[ ] Surgery (Specify)
[ ] Tuberculosis
[ ] Vision Difficulty
[ ] Weight Problems
[ ] Other (Specify)
[ ] None of the listed conditions apply

COMMENTS: _____
_____

2. Does your child have allergies to medicine, food, latex or insect bites? [ ] NO [ ] YES
   Allergic to what: _____ What happens _____
   Treatment: _____
3. Has your child had any illness since school ended last June? [ ] NO [ ] YES
   Type of illness with date(s)_____
4. Has your child had any surgery in the last 12 months? [ ] NO [ ] YES
   Type of surgery with date(s)_____
5. Has your child received any immunizations in the last 12 months? [ ] NO [ ] YES
   List immunizations with date(s) _____
6. Is your child being treated or evaluated for any health condition? [ ] NO [ ] YES
   List condition(s) _____
7. Is your child on any medications or treatments? [ ] NO [ ] YES
   Name of medication(s) or treatment(s)_____
   Does your child need medication during school hours? [ ] NO [ ] YES
   ****IF YES, YOU <u>MUST</u> CONTACT THE SCHOOL NURSE AND MAKE THE NECESSARY ARRANGEMENTS**
8. Has your child ever been examined by an eye doctor? [ ] NO [ ] YES
   Date of last exam _____ [ ] Normal [ ] Glasses/Contacts prescribed
   When should your child wear his/her glasses/contacts _____
9. Has your child had any emotional upsets (recent move, death, separation, divorce) in the last 12 months? [ ] NO [ ] YES
   Please list: _____
10. Has your child had any injuries or fractures in the last 12 months? [ ] NO [ ] YES
    Type of injury/fracture_____
    List any limitations due to injury: _____
11. What was the date of your child's last dental exam?_____ Concerns_____
    Does your child have braces? [ ] NO [ ] YES
12. What was the date of your child's last physical examination? _____

Thank you for helping to keep your child's School Health Record up to date.
If there are any changes during the school year, please inform the school nurse of these changes.