DIVINE SAVIOR CATHOLIC SCHOOL

Uniting Faith and Knowledge

Kiel & New Holstein Wisconsin

Student Health History

The purpose of this form is to provide important information about the health history of the students. Please fill out this form as accurately and completely as possible. Each year you will be asked to update this information.

Name ________________________________ Grade _________ Phone __________________

Address ____Date of birth ______________

Please check an of the following that apply:

___ Bleeding or clotting disorder
___Asthma
___Diabetes
___Nosebleeds
___ Hearing Impairment
___Other (please specify)
___ Heart Defect or Disease
___Seizures
___Motion Sickness
___Fainting
___ Wears glasses or contacts
___ Wears a knee or ankle brace

Allergies? (please check)

___Hay Fever
___ Penicillin
___Pollen
___Insect stings
___Other drugs
___Other allergies (please specify)

Is your child taking any medication? ___ If so what? _________________________________

Does your child use an inhaler?_____ How often can it be used ________________________

Please list any other medical condition the staff should be aware of regarding this student.

Health Insurance Carrier ______________________________________ Policy # _______________

Subscriber Name ____________________________

In case of emergency, I understand every effort will be made to contact me. In the event I cannot be reached, I hereby give my permission to the physician selected by the adult in charge to secure proper treatment for my child. This could include hospitalization, anesthesia, surgery or injection of medication.

Signature of Parent ___________________________________ Date _______________

Please fill out a new form as soon as possible if there are any major changes in your child's health information.