HOLY INFANCY SCHOOL

Bethlehem Area School District
HEALTH HISTORY

Name _____ Date of Birth _____

M / F School _____ Grade/Homeroom _____

Mother's Name _____ Address _____

Father's Name _____ Address _____

Custody Arrangements _____

Last School Attended _____ County _____

Siblings:

Name	Age

Language Spoken at Home _____

Name of Doctor/Clinic _____ Dentist _____

Immunization Record -Please attach

Hospitalizations and Surgeries

Date	Diagnosis	Procedure	Resolution

Serious Injuries

Date	Type	Resolution

Chronic or Serious Medical Conditions

Date	Type	Resolution

Medications Taken Regularly

Name of Medication	Dose	Time	Reason

Allergies

Medications _____
Insects _____
Foods _____
Other _____

Emotional Problems

Description _____

Resolution _____

_____ _____
Parent/Guardian Signature Date

Rev. 10/2012