St. Jane Frances de Chantal School
Health Information Form

Child's Name_____ Grade _____ Birthdate _____M___F___
Mother_____ Home #_____Cell # _____Work # _____
Address_____
Father_____ Home #_____Cell # _____Work # _____
Address_____

Prenatal, Birth History, Behavioral Concerns during Infancy and Childhood:

Birth Weight _____ Were there any complications during pregnancy? Yes____ No____
If **Yes**, please explain_____
Were there any developmental delays / concerns during infancy / early childhood? Yes____ No____
If **Yes** please explain_____

Does you child have a history of any of the following: (Please check)

__Feeding Problems	__ Bed-Wetting	__Unusual tics/twitches	__Poor Coordination/Balance
__Short attention span	__ Behavior Problems	__Unusual fears	__Hyperactivity
__Unusual Sleep Patterns	__ Difficulty with peers	__Frequent falls	__Difficulty expressing needs
__Bowel/bladder problems	__ Nail biting	__Fainting	__Headaches
__Separation anxiety	__Bruise easily		

If any of the above were checked**,** please explain _____
_____

Does Your Child Have an Allergy To: (please write the specific allergy)

Food_____ Bee Stings_____ Medications _____Other_____

Has an EPI-PEN been ordered for this allergy? Yes ___ No___
Is there any other medication required for this allergy? Yes ___ No___
If yes, please list the name of the medication and dosage: _____
When happens when your child has a reaction? _____
Other allergy concerns or instructions for treatment? _____
_____

Does Your Child Have an Ongoing Medical Condition: Yes ___ No ___
If Yes, please identify _____
_____

Does Your Child Take Daily Medication: Yes___ No ___
Name of medication(s) and dosage: _____
_____

Indicate Condition(s) That Your Child Is Taking the Medication(s) For:

_____
_____

***IMPORTANT* Please Complete Reverse Side** **Turn Over >**

Has Your Child Had Any Of The Following: (Please indicate date)

Chickenpox	Yes____ Date_____	Measles	Yes___ Date_____
Roseola	Yes____ Date_____	Asthma	Yes___ Date_____
Meningitis	Yes____ Date_____	Seizures	Yes___ Date_____
Scarlet Fever	Yes____ Date_____	Epilepsy	Yes___ Date_____
Heart condition(s)	Yes____ Date_____	Weight concerns	Yes___ Date_____
Blood Disorder	Yes____ Date_____	Diabetes	Yes___ Date_____
Other _____	Yes____ Date_____		

Complications of illness and treatment required _____

_____

Does Your Child Have A History Of:

Serious Injury Date____ Type _____
Surgery Date ____ Type _____
Hospitalizations Date ____ Type _____
Orthopedic problems Date ____ Type _____
Earaches/Infections Date ____ Reason_____
High Blood Pressure Date ____ Treatment _____
Head Injury Date ____ Type _____
Additional information or treatment _____

_____

Does Your Child Have:

Vision problems Yes ___ No ___ Close up or distance vision or both (please circle)
Glasses / contacts Yes ___ No ___ Glasses for close up or distance vision or both (please circle)
Hearing problems Yes ___ No ___ Right ear or left ear or both (please circle)
Hearing aide Yes ___ No ___ Right ear or left ear or both (please circle)
Speech problems Yes___ No___
Stuttering Yes___ No___
Additional concerns/treatment/therapy _____

_____

_____

Primary Health Care Providers:

Child's Doctor_____ Phone _____
Child's Dentist_____ Phone_____
Child's Specialist Physician _____ Phone _____
Previous School District_____ City _____ State _____

Any additional information you would like the school nurse to have: _____

_____

_____

The above information may be shared with appropriate school personnel at the nurse's discretion on a need to know basis, unless otherwise requested.

Signature of Parent/Guardian_____ Date _____