

# Saint Thomas Academy Student Health Form

Child's Name: \_\_\_\_\_ Parent's Name: \_\_\_\_\_

Birthdate: \_\_\_\_\_ Phone (H) \_\_\_\_\_

Grade: \_\_\_\_\_ Phone (W) \_\_\_\_\_

1. Is there anything you wish to discuss with the nurse about your child's physical or emotional health?	YES	NO
2. Is there any physical and/or emotional reason that your child may need special consideration in the classroom situation or do you anticipate any adjustment in his school program?	YES	NO
3. Does your child have any of the following:		
a. Allergic reaction to food or drug? What?	YES	NO
b. Ongoing health conditions we should be aware of?	YES	NO
c. Asthma?	YES	NO
d. Medications taken for asthma? Name of medication?	YES	NO
e. Problems in vision, hearing, speech, special shoes, etc? Please indicate problem.	YES	NO
f. History of Hospitalization (other than tonsillectomy or appendectomy)? Please indicate reason.	YES	NO
g. History of illness at birth?	YES	NO
h. History of behavior concerns?	YES	NO
4. Does your child regularly take medication or therapy at home or at school? Please describe.	YES	NO
5. Is the school emergency card completed?	YES	NO
6. Are your child's immunizations complete?	YES	NO
7. Date of last : MMR _____ TD _____		

Please return this form to the school nurse.  
Please use the back of form for any additional comments.