***DATE*_____**

Lebanon Catholic School
Student Health Information

*Student's Name*_____ *M/F*_____ *Grade*_____
Last *First*

*Birth date*_____ *Telephone*_____

*Address*_____

*Parent's Name: Father*_____
Last *First* *M.I.*

*Mother*_____
Last *First* *Maiden Name*

Has your child had any childhood illnesses? **Yes** **No**
Does your child have heart problems? **Yes** **No**
Does your child have diabetes? **Yes** **No**
Has your child had any trouble with ears or hearing? **Yes** **No**
If yes, what age? _____
Has your child had any trouble with eyes or seeing? **Yes** **No**
If yes, what age? _____
Has your child ever had a convulsion? **Yes** **No**
If yes, explain_____
At what age? _____
Does your child have allergies? **Yes** **No**
f yes, name_____
Does your child have asthma? **Yes** **No**
If yes, name medication_____
Has your child ever had a reaction to any medicine or injections? **Yes** **No**
_____
If yes, name medication_____
Has your child ever been in the hospital? _____ **Yes** **No**
Reason_____
When_____ Name of Hospital_____
Has your child had any accidents, broken or fractured bones? **Yes** **No**
_____
Explain_____
When_____
Is your child under doctor's care at present? _____ **Yes** **No**
Reason_____
Physician_____
Is your child taking medicine other than vitamins? **Yes** **No**
_____
If yes, what medicine_____
Previous school attended_____ **Yes** **No**