HEALTH HISTORY FORM
(To Be Completed by Parent)

HOLY SPIRIT SCHOOL

HAS YOUR CHILD HAD:

	YES	NO	DATE/EXPLAIN
Diabetes			
Racing heart/Skipped Heart Beats			
Heart Murmur			
Chicken Pox			
Rheumatic Fever			
Mononucleosis			
Asthma			
Pneumonia			
Frequent Sore Throats			
Frequent Ear Infections			
Frequent Vomiting or Diarrhea			
ADD			
Trouble with Hearing			
Difficulty with Speech			
Trouble with Vision			
Tendency to Bleed Easily			
Eczema			
Medication Allergies			
Allergies to Food, Beestings, Latex or Pollen			
Any Severe Injury			
Any Operations			
Pre-K & Kindergarten Only:			
Nail Biting or Thumb Sucking			
Breath Holding or Temper Tantrums			
Difficulty with Toilet Training			
Premature Birth/Difficulty w/pregnancy or labor			

Daily Medication, Emergency Medication or Inhaler:_____

Is there any additional information that we should know so that we can better care for your child or that might affect his/her progress?

_____

_____

Child's Full Name:_____

Date of Birth:_____Grade:_____

Address:_____ Phone #:_____

Father's Name:_____Mother's Name:_____

Signature: Parent/Guardian_____Date:_____