

SOUTH COUNTRY CENTRAL SCHOOL DISTRICT
HEALTH HISTORY REGISTRATION FORM

GRADE _____ SCHOOL _____ DATE _____

1. Name of Student _____ Tel. No. _____

2. Address _____

3. Date of Birth _____ Birthplace _____

4. Name of Mother _____ Birthplace _____

5. Name of Father _____ Birthplace _____

6. Does your child have any health concerns? Yes _____ No _____
Asthma Yes _____ No _____ Allergies Yes _____ No _____ Other _____

7. Is your child on any medication? _____ Name of Medication: _____

8. Any restrictions on activity? _____

9. Is there a history of Tuberculosis in the family? _____

10. Has pupil ever had an operation? _____ Type _____ Date _____

11. Family Physician _____ Tel. No. _____

If parent cannot be reached in case of emergency, person to contact

Name _____ Tel. No. _____

Past history of illnesses. State year in which illness occurred.

- | | |
|--------------------------|-----------------------|
| Epilepsy _____ | Kidney Trouble _____ |
| Chicken Pox _____ | Pneumonia _____ |
| Measles _____ | Rheumatic Fever _____ |
| Mumps _____ | Tonsillitis _____ |
| Whooping Cough _____ | Frequent Colds _____ |
| German Measles _____ | Hearing Loss _____ |
| Asthma _____ | Vision Problems _____ |
| Diabetes _____ | Heart Problems _____ |
| Anemia/Sickle Cell _____ | Skin Disorders _____ |
| Mononucleosis _____ | Hernias _____ |

Parent /Guardian Signature _____