SAINT AMBROSE SCHOOL

STUDENT HEALTH HISTORY

Student's Name:_____ Today's Date: _____

Parent's Name:_____ Address: _____

Date of Birth:_____ Phone Number:_____

Physician:_____ Physician's Phone Number:_____

Does your child have any of the following :

Allergies_____

Allergies which require Epinepherine :_____

Asthma:_____Medications for Asthma :_____

Frequent nose bleeds :_____ Wears glasses:_____

Hearing problems :_____ Preferential seating:_____

Convulsions :_____Medications for convulsions :_____

Diabetes: Type 1_____ Type 2_____ Medications for diabetes:_____

Other Medical/Mental Health Diagnosis_____

_____

Is your child taking any medication now? _____ If yes, please list below:

_____

_____

Prior Hospitalizations/Surgeries:

_____

Any other information you would like to share which would be helpful in understanding your child better thus enabling him/her to benefit fully from school experiences?

_____

_____