St. Brigid School
Excellence Faith Community

Student Health History Form 2025-2026

Student's name: _____ Preferred name: _____

Date of Birth: _____ Male: ☐ Female: ☐ Grade: _____ Teacher: _____

Parent/Guardian: _____ Phone: _____

Parent/Guardian: _____ Phone: _____

Please indicate any medications given at home, the dose, frequency and the reason for the medication.

HOME MEDICATION	DOSE	FREQUENCY	REASON GIVEN

ALLERGIES ☐ None Known ☐ Yes, specify details below

	NAME/TYPE	REACTION	TREATMENT
ANIMALS & INSECTS			
ENVIRONMENTAL			
FOODS			

HEALTH HISTORY – Please check if you child has ever had or currently has any of the following:

- ☐ ADD/ADHD
- ☐ Arthritis
- ☐ Asthma
- ☐ Autoimmune disease
- ☐ Birth defect
- ☐ Blood disorder
- ☐ Cancer (please specify)
- ☐ Cognitive disorder
- ☐ Concussion
- ☐ Dental disease
- ☐ Diabetes
- ☐ Digestive disease
- ☐ Eye conditions
- ☐ Fractured/Broken Bones
- ☐ Genetic disorder
- ☐ Glasses/Contact Lenses
- ☐ Migraines
- ☐ Hearing loss
- ☐ Heart disease
- ☐ Hepatitis
- ☐ Hospitalizations
- ☐ Kidney or urinary disease
- ☐ Lung disease
- ☐ Mental Health conditions
- ☐ Organ transplant
- ☐ Physical limitations
- ☐ Reproductive conditions
- ☐ Seizures
- ☐ Skin conditions
- ☐ Surgery
- ☐ Thyroid disease
- ☐ Other

Please provide additional information (dates, ages, treatments, ongoing care, etc.):

_____

_____

_____

_____

By signing below, I understand this form must be updated prior to the beginning of each school year so that my child can remain in attendance.

Parent/guardian signature: _____ Date: _____