St. Elizabeth Ann Seton Academy
909 Lonsdale Avenue
Central Falls, RI 02863
(401) 728-6230

Date: _____

STUDENT HEALTH HISTORY

Name of Student: _____ Grade: _____
Last First Middle

Street Address: _____ City/State: _____ Zip: _____

Date of Birth: _____ Sex: M F Telephone: _____

Father's Name: _____ Mother's Name: _____

Language Spoken at Home: _____ Physician' Name: _____

Allergy (type): _____

Does your child need emergency medication? (please explain) _____

_____

Please check if your child has/had any of the following:

- ☐ Asthma
- ☐ Chicken Pox
- ☐ Diabetes
- ☐ Ear Infections
- ☐ Glasses
- ☐ Hearing/Vision Problems
- ☐ Heart Disease
- ☐ Heart Murmur
- ☐ Hepatitis
- ☐ Kidney Disease
- ☐ Lead
- ☐ Lyme Disease
- ☐ Measles
- ☐ Migraines
- ☐ Mononucleosis
- ☐ Musculoskeletal Disorder
- ☐ Pneumonia
- ☐ Rheumatic Fever
- ☐ Scarlet Fever
- ☐ Seizure Disorder
- ☐ Sickle Cell
- ☐ Special Health Care Needs
- ☐ Strep Infections
- ☐ TB
- ☐ Upper Respiratory
- ☐ Other _____
  _____

Injuries/Operations: _____

Hospitalizations: _____ Date: _____

Does your child take daily medication? No / Yes - Explain: _____
_____

I understand that the above information may be shared with school personnel if necessary.

_____ Date: _____
Parent/Guardian Signature