

Saint Katharine Drexel School  
503 South Spring Street  
Beaver Dam, Wisconsin 53916  
Phone: 920-885-5558 Fax: 920-885-7610 Website: www.skds.org



\_\_\_\_\_  
Today's Date

**HEALTH HISTORY FORM**

In order for your child to register and attend school, this form must be completed, signed and returned to school. Please complete this form before taking your child to the doctor.

Child's Name: \_\_\_\_\_ Birth Date: \_\_\_\_\_  M  F

Child's Address: \_\_\_\_\_ Home Phone: \_\_\_\_\_

Father's Name: \_\_\_\_\_ Mother's Legal First/Last Name: \_\_\_\_\_

E-mail Address: \_\_\_\_\_

Please answer YES or NO after each item.

Family history of: Tuberculosis \_\_\_\_ Cancer \_\_\_\_ Heart Disease \_\_\_\_ Diabetes \_\_\_\_ Thyroid Problem \_\_\_\_  
High Blood Pressure \_\_\_\_ Emotional Problem \_\_\_\_ Learning Problem \_\_\_\_

History of child's illness: Diabetes \_\_\_\_ Seasonal Allergies \_\_\_\_ Kidney Problem \_\_\_\_ Seizures \_\_\_\_ Asthma \_\_\_\_  
Rheumatic Fever \_\_\_\_ Congenital Heart Disease \_\_\_\_ Ear Infections \_\_\_\_ Rubeola (hard measles) \_\_\_\_  
Rubella (German measles or 3-day measles) \_\_\_\_ Mumps \_\_\_\_ Chicken Pox \_\_\_\_ Whooping Cough \_\_\_\_  
Scarlet Fever \_\_\_\_ Strep Throat \_\_\_\_ Infectious Hepatitis (infectious jaundice) \_\_\_\_ Other \_\_\_\_\_

Does your child have problems with any of the following? Skin \_\_\_\_ Eating \_\_\_\_ Bowels \_\_\_\_ Urination \_\_\_\_  
Sleeping \_\_\_\_ Muscles or bones \_\_\_\_ Heart or Lungs \_\_\_\_ Food Allergies \_\_\_\_ Bee Sting Allergies \_\_\_\_

If you answered yes to any of the problems listed in the question above, please describe \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Has your child had any serious injuries?(Y/N) \_\_\_\_ If yes, please describe \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Has your child ever been hospitalized? (Y/N) \_\_\_\_ If yes, Reason \_\_\_\_\_

Does your child take any medications regularly? (Y/N) \_\_\_\_ If yes, Medication name \_\_\_\_\_  
Frequency \_\_\_\_\_ Reason \_\_\_\_\_

Has your child ever had a TB skin test? (Y/N) \_\_\_\_ If so, When? \_\_\_\_\_ Results \_\_\_\_\_

Does your child wear glasses? (Y/N) \_\_\_\_ Color Blind? (Y/N) \_\_\_\_ Does your child have a hearing problem? (Y/N) \_\_\_\_

Wears a hearing aid? (Y/N) \_\_\_\_ Was your pregnancy with this child: 9 months \_\_\_\_ Longer \_\_\_\_ Shorter \_\_\_\_

Any illness during pregnancy? (Y/N) \_\_\_\_ If yes, please describe \_\_\_\_\_

Any complications at delivery (mother or baby) (Y/N) \_\_\_\_ If yes, please describe \_\_\_\_\_