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 _____