

# IMMACULATE CONCEPTION SCHOOL SCHOOL ENTRANCE HEALTH HISTORY

Name \_\_\_\_\_ Grade \_\_\_\_\_ Birth Date \_\_\_\_\_ Sex \_\_\_\_\_

Daytime Phone # \_\_\_\_\_ Cell Phone # \_\_\_\_\_

## Health History

**Life Threatening Allergic Conditions: (Check all that apply)**

- Severe allergic reaction to Bee Stings, other insects: \_\_\_\_\_
- Severe reaction to Nut, Peanuts: \_\_\_\_\_
- Severe reaction to other Food Products: \_\_\_\_\_
- Other severe allergies affecting school: \_\_\_\_\_

Please indicate any of your child's symptoms which would indicate a severe allergy: (Local swelling does not indicate a severe allergic reaction.)

- Itching and/or tightness in the throat, hoarseness
- Itching or swelling of the eyes, lips, tongue or mouth
- Shortness of breath, coughing, and/or wheezing
- "Thready pulse", "passing out"/loss of consciousness
- Hives

Has your physician prescribed an Epi-Pen or other medicine for a severe life threatening allergy?  Yes\*  No  
Specify medication: \_\_\_\_\_ \*If you answered "Yes", please contact the school, 419-483-6066.

Does your child have a history of any of the following conditions, if yes please circle and explain below:

Developmental Delay	Yes	Heart Disease	Yes	Pre-mature Birth	Yes
Surgeries/Hospitalizations	Yes	Chicken Pox	Yes	Ear Infections or Tubes	Yes
Asthma	Yes	Kidney Disease	Yes	Hearing Problem or Aides	Yes
Blood Disorder	Yes	Nervous System Disorder	Yes	Mental Illness	Yes
Cancer	Yes	Skin Disorder	Yes	Behavioral Problems	Yes
Convulsions/Seizures	Yes	Stomach/Intestinal Disorder	Yes	Head Injury	Yes
Diabetes Type I or Type II (circle one)	Yes	Glasses/Contacts used full-time or for reading only (circle one)	Yes	Currently Under a Doctor's Care	Yes

Please explain any "Yes" answers to the above: \_\_\_\_\_

Describe any physical condition/disabilities not listed above: \_\_\_\_\_

Are there any precautions/limitations in school activities Yes/No \_\_\_\_\_  
Family Health History that the school should be aware of \_\_\_\_\_

### Medications: Please list

Name of Medication	Dosage	Time of Day	Reason

I understand that if my child's health status changes, I will provide Immaculate Conception School with the updated information at 419-483-6066.

Parent/Guardian Signature \_\_\_\_\_ Date \_\_\_\_\_