 **St. Mary’s Springs Academy**

**Health History Form 2017-2018**

**Student:**

**Last Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ First Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Middle:\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Age: \_\_\_\_\_\_\_\_\_    Grade: \_\_\_\_\_\_\_\_\_ Guardian Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Medical Conditions: Check any of the following your child has had or now has. List any RECENT conditions, illnesses, surgeries, hospitalizations not mentioned:**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **HEALTH CONCERN** | **YES** |  | **HEALTH CONCERN** | **YES** |
| **NO HEALTH CONCERNS** |  |  | Hearing Impairment |  |
| Physical Impairment |  |  | Heart Trouble |  |
| Asthma   Requires inhaler at school    yes   no   (please circle)   Requires nebulizer                yes   no |  |  | High Blood Pressure |  |
| Visual Impairment |  |  | Lowered Immunity (cancer, transplant, etc.) |  |
| Chicken Pox    Date: |  |  | Skin Conditions |  |
| Concussion/Head Injury    Date(s): |  |  | Seizures |  |
| Diabetes: Type 1 or 2 (please circle) |  |  | Mental Health/Behavioral Health Concerns |  |
| Frequent Nosebleeds |  |  | Additional Comments: | |
| Headaches/Migraines |  |  |  | |
| **Allergy:** (circle all that apply & specify type)   Bee Stings           Insect bites   Food                      Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_   Environmental       Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_   Medication            Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_   Other                     Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_   Epi pen required:  yes  /   no |  |  | Medications (name/dosage/time taken):  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | |

**6th-12th:** One Tdap (Tetanus/Diphtheria/Acellular Pertussis) adolescent booster is required.

Date of last Tdap or Td (please circle which) \_\_\_\_/\_\_\_\_/\_\_\_

**If your child has any health condition(s) that you would like to discuss with the school nurse, please contact SMSA Katie Hellmer at Health Services (920) 322-3206 or khellmer@smsacademy.org.**

**Parent Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date:\_\_\_\_\_\_\_\_\_\_\_\_\_**