St. Mary's Springs Academy
Health History Form 2020-2021

Student:
Last Name:_____ First Name:_____Middle:_____

Age:_____ DOB:_____ Grade:___ Parent/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) ____/____/___

Please contact Patti Shippee, RN at (920)322-3206 or pshippee@smsacademy.org if you have any questions or concerns.

Parent Signature:_____Date:_____