

St. John the Baptist Catholic School

Health Questionnaire

(Parent/Guardian need to complete)

Student _____ Date of Birth _____

Address _____

Phone Number _____ Grade _____ Room # _____

Father's Name _____ Mother's Name _____

Student lives with _____

Disease/Condition	Yes (List mo./yr)	No	Disease/Condition	Yes (List mo./yr)	No
Asthma			Mumps		
Diabetes			Rheumatic Fever		
Seizures			Rubella		
Chickenpox			Scarlet Fever		
Measles			Other		

Has your child had an infectious/communicable disease other than those listed above?

Please explain giving relevant dates _____

Please list any of the following with the month/year

Operations _____

Illnesses (eye, ear, heart, stomach, kidney) _____

Severe Injuries (head injury, fractures, etc.) _____

Is there any other information about your child's health status that you think the school should know which may be relevant to your child's health and safety or the health and safety of others in the school environment? _____

Please list any condition that should be considered in planning your child's school day

Allergies/Reactions _____

Physician Name _____ Phone # _____

Dentist Name _____ Phone # _____

To the best of my knowledge the above information is complete and accurate. I acknowledge that I have a continuing obligation to inform the school of any changes in my child's health status that are relevant to the information requested by this form.

Parent Signature _____ Date _____