



ST. MARK
Building for Life

Confidential Health History

2010-2011



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St. Mark Lutheran School/Extended Care • 1515 Hillendahl, Houston, TX 77055
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www.stmarkhouston.org

NAME: _____
(LAST) (FIRST) (MI)

D .O.B. _____ GRADE ENTERING _____

Does your child have any, or has your child had any, problems with any of the medical issues listed below? (Please check where appropriate)

Respiratory/Asthma	<input type="checkbox"/>	Dizziness/Fainting	<input type="checkbox"/>	Heart disease or cardiovascular	<input type="checkbox"/>
Stomach/Intestinal	<input type="checkbox"/>	Kidney/ Bladder	<input type="checkbox"/>	Bone/ Joint disease	<input type="checkbox"/>
Headache/Migraine	<input type="checkbox"/>	Seizures/Convulsions	<input type="checkbox"/>	Diabetes/Weight issues	<input type="checkbox"/>
Nervousness/Anxiety	<input type="checkbox"/>	Emotional Issues	<input type="checkbox"/>	ADD/ADHD/Hyperactivity	<input type="checkbox"/>
Prematurity	<input type="checkbox"/>	Birth Defects	<input type="checkbox"/>	Anemia	<input type="checkbox"/>
Chronic Illness	<input type="checkbox"/>	Hypertension	<input type="checkbox"/>	Other	<input type="checkbox"/>

If you checked any of the above, please provide an explanation. Please indicate if the student is currently receiving treatment, and if so, please be specific as to the type of treatment, and provide the name of the treating physician.

Does your child have any allergies to the following? (Please check where appropriate)

Bees/Wasps	<input type="checkbox"/>	Ants	<input type="checkbox"/>	Milk/Cheese	<input type="checkbox"/>
Peanuts/Nuts	<input type="checkbox"/>	Chocolate	<input type="checkbox"/>	Seafood	<input type="checkbox"/>
Corn/Wheat	<input type="checkbox"/>	Medication	<input type="checkbox"/>	Other	<input type="checkbox"/>

If you checked any of the above, please provide an explanation of symptoms and effective treatments (creams, medications, allergy shots, etc.)

Has your child ever experienced any of the following? (Please check where appropriate)

Surgery/Operations	Serious Accident/Injury	
Frequent/Recurrent colds	Frequent/Recurrent Ear Infections	
Scarlet Fever	Cold sores	
Hepatitis	Chicken Pox	

If you checked any of the above, please provide dates, and explain.

Does your child experience any of the following? (Please check where appropriate)

Speech Impediment/Language Difficulty	
Vision Trouble/Glasses/Contacts	
Hearing Loss/Hearing Aides	
Physical Handicap/Special needs	
Learning Disability/Hindrance	

Please give a brief explanation:

Does your child take medication on a regular basis? Yes ____ No ____
If YES what medication and what dosage?

Will the student take the medication at school? Yes ____ No ____
If YES please refer to the medication policies, and prepare accordingly. Thank You!

Is there anything more about your child/child's health that the school nursing staff should know, or that might be relevant to his/her care?

When was the last time your child was examined by a physician? _____

What was the reason for that examination? _____