ST. JOHN SCHOOL

HEALTH HISTORY FORM

*****THIS IS A TWO-SIDED FORM. PLEASE COMPLETE BOTH SIDES*****

(Please Print)

Student's name:_____

Home Address:_____

_____

	YES	NO
Any illness lasting longer than 5 days?	____	____
Presently taking any medicine or under MD care?	____	____
Wear glasses or contact lenses?	____	____
Any chronic diseases? (asthma, diabetes, etc.)	____	____
Any known allergies?	____	____
Bee sting Allergy? If yes, is an Epipen needed?	____	____
Is there a need for your child to avoid prolonged exposure to the sun?	____	____

If you answered, "yes" to any of the above, please describe:

_____
_____
_____
_____

Please list any medications that your child will bring along with the dosage and times the medication should be taken:

_____
_____
_____
_____

I hereby give my permission for the class teacher to act on my behalf to provide or secure emergency medical treatment for my child.

_____
Print Student's Name

_____
Parent/Guardian signature

_____
Printed Parent/Guardian Name

_____
Date

_____ _____
Insurance Company Policy Number

Parent Phone for the duration of the field trip_____ (please indicate if it is work_____, cell____, or home_____)

Emergency Contact person (someone we can contact if we can't contact you)

Name:_____

Relationship to child:_____

Phone Number:_____