Student Health File

Name :

Has your child ever suffered or is your child currently suffering from any of the following conditions?

1. Asthma	Yes __ No __	If yes, please give details:
2. Allergies	Yes __ No __	If yes, please give details:
3. Has your child ever shown an allergic reaction to a wasp / bee sting? Yes ___ No ___		
4. Diabetes	Yes __ No __	If yes, please give details:
5. Heart Disease	Yes __ No __	If yes, please give details:
6. Hearing Disorder	Yes __ No __	If yes, please give details:
7. Visual Disorder	Yes __ No __	If yes, please give details:
8. Skin Disorder	Yes __ No __	If yes, please give details:
9. Neuromuscular Disorder	Yes __ No __	If yes, please give details:
10. Orthopedic condition	Yes __ No __	If yes, please give details:
11. Seizure disorder	Yes __ No __	If yes, please give details:
12. Other (Please specify)		

13. Is your child taking any medication regularly?   Yes ____   No _____
If yes, please specify:

Does medication have to be administered during school hours?

Yes ____   No _____

14. Immunization Record		
BCG 1. / /	Polio 1. / / 2. / /	
DPT Stage 1 1. / / 2. / / 3. / / 4. / /		
DT Stage 2 1. / /	MR 1. / / 2. / / 3. / /	
Measles / /	Rubella / /	
Mumps / /	Japanese encephalitis 1. / / 2. / / 3. / /	
15. Child`s blood type (if known)		
16. Has your child ever been diagnosed with, seen or recommended to see a therapist because of: If yes, please provide copies of all applicable records.	Yes ____ No ____ a) A learning disability: autism, Asperger syndrome, dyslexia, dyscalculia, dysgraphia, attention disorders (e.g. ADHD), _____. b) A developmental delay: speech, language, motor skills, _____. c) Others (please specify) _____ _____	
17. Has your child ever been enrolled or recommended to enroll in a special needs or gifted and talented program?	Yes / No If yes please give details _____ _____	
18. Is there anything else we should know?		

I hereby confirm the accuracy and completeness of the above information.

Date: _____
        (day/month/year)

Signature: _____