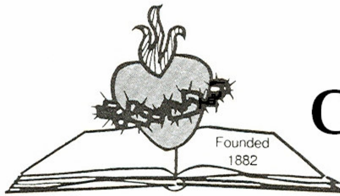

Sacred Heart Catholic School

Gervais

PUPIL MEDICAL RECORD

Confidential Information

Student's Name ______________________________ School **Sacred Heart School** Grade: _____ Birthday ______ Sex: M F

Address: ____ Phone: ______________________________
Street or P.O Box City State Zip

Parent or Guardian ____________________________ Father Wk. Ph. _____________ Mother Wk. Ph. ______________________

Name of Physician ____ Phone: ______________________________

PARENT'S EVALUATION OF STUDENT'S HEALTH		
1. Does your student have a physical handicap? If yes, please state the nature of the condition:	☐ YES ☐ NO	
2. Has your student ever had an operation? If yes, please state nature of operation and date performed:	☐ YES ☐ NO	
3. Has your student ever had a severe injury? If yes, please explain and give date of injury:	☐ YES ☐ NO	
4. Does your student have any of the following? ☐ ADD/ADHD		
☐ Asthma *Please circle applicable triggers*: Animal Dander, Dust/Dust Mites, Exercise Induced, Mold		
☐ Bladder/Bowel Disorder		
☐ Blood Disorder		
☐ Brain Injury		
☐ Diabetes *Please circle*: Type 1 Type 2		
☐ Ear/Eye Disorder		
☐ Heart Problem		
☐ Seizure Disorder		
☐ Severe Allergy with Epinephrine prescribed. *Please specify allergen:*		
☐ Suppressed Immune System		
☐ Other health problems *Please specify:*		
5. Is your student presently under a doctor's care for a particular illness? If so, please state nature of illness:	☐ YES ☐ NO	
6. Is he/she taking medication? If yes, should he/she take medication at school? Please state nature of illness and name of medication:	☐ YES ☐ NO	***Note:*** An additional form must be completed for all medications taken at school.
7. Is your student able to participate in full activity at school? If no, please explain:	☐ YES ☐ NO	
8. Has your student been hospitalized recently?	☐ YES ☐ NO	If yes, what year? __________
____________________________________ SIGNATURE OF PARENT OR LEGAL GUARDIAN		____________________ DATE