HEALTH INFORMATION

Child's Name	**Date of Birth**
Address	
Mailing Address (if different)	
Home Phone	**Bus. Phone**
Family Physician	**Phone #**

HAS YOUR CHILD HAD ANY OF THE FOLLOWING DISEASES?
If so please write date:

Chicken Pox	Mumps	Scarlet Fever	Heart Disease	Frequent Colds
Diptheria	Pneumonia	Whooping Cough	Tuberculosis	Contact with Tuberculosis
German Measles	Poliomyelitis	Diabetes	Asthma	Frequent Sore Throats
Measles	Rheumatic Fever	Epilepsy	Allergies	
Serious Injuries		Operations		

Has your child ever had any ear problems? _____
Explain: _____
_____
_____

Has your child had any vision screening? _____
Explain: _____
_____
_____

Is there anything concerning the health of your child which the school should know in order to help the child in any way?

_____
_____
_____
_____

Parent Signature Date