ST CATHERINE OF SIENA SCHOOL
New Student Health Survey (To Be Completed by Parent/Guardian)

Student Name: _____ DOB: _____ Grade: _____

Gender: _____ Name of Doctor: _____

Please check if your child has had the following:

Condition	Yes	No	Year	Condition	Yes	No	Year
High blood pressure							
Asthma				TB or contact with TB			
Severe Allergies				Severe or chronic stomach problems			
Frequent or painful urination				West or soils pants			
Concussion				Frequent or severe headaches			
Dizzy or fainting spells				Severe head injury			
Epilepsy				Excessive worry or anxiety			
Depression				Hearing loss			
Speech problems				Eye problems			
Frequent ear infections				Frequent colds			
Wears glasses or contacts				Diabetes			
Scoliosis				Tumor			
Cancer				Serious skin disease			

1. Has your child ever had any serious illnesses or injuries other than those already noted? What? When?
   Explain: _____
   _____
2. List any medications or foods your child is allergic to: _____
3. Has your child been diagnosed with Attention Deficit Disorder? Explain: _____
   _____
   List any medications: _____
4. Had your child had any operations? What? When? Explain: _____
   _____
5. Has your child had any orthopedic (bone or joint) problems? What? When? Explain: _____
   _____
6. Does your child have severe bee sting sensitivity? Local _____ General _____ Explain: _____
   _____
7. Does your child have other health or behavior problems the Nurse should be aware of? Explain: _____
   _____
8. Is your child under regular medical supervision for any of the above conditions? If yes, give name of the physician: _____
9. Please explain any "YES" answers here: _____
   _____
10. Normal pregnancy and delivery? Yes _____ No _____ If No, explain: _____
11. Please contact the School Nurse if you have any questions or concerns.

Parent/Guardian Signature _____ **Date** _____ 5/2016