

# HEALTH QUESTIONNAIRE AND PERMISSION FOR TESTING PROGRAMS

Student \_\_\_\_\_ Birth Date \_\_\_\_\_ Grade \_\_\_\_\_

Parents \_\_\_\_\_

Address Where Student Resides \_\_\_\_\_

Home Phone Number \_\_\_\_\_

Father's Place of Employment \_\_\_\_\_ Phone Number \_\_\_\_\_

Mother's Place of Employment \_\_\_\_\_ Phone Number \_\_\_\_\_

Child's Physician \_\_\_\_\_ Phone Number \_\_\_\_\_

Child's Dentist \_\_\_\_\_ Phone Number \_\_\_\_\_

Hospital Preference: \_\_\_\_\_

**If your child is on medication prescribed by your doctor, please ask your doctor for an order for same. We are not permitted to give medication of any kind, including aspirin or cough drops, without an order form from your doctor.**

PLEASE ATTACH A COPY OF YOUR CHILD'S  
CURRENT IMMUNIZATION RECORD TO THIS FORM.

Physical History	Year	Physical History	Year
Accident – Serious		Illness – Serious	
Allergy – Drug/Other		Measles	
Asthma		Mumps	
Blood Disorder		Neurological Disorder	
Cardiac Disease/Problem		Ear Infection	
Chicken Pox		Rheumatic Fever	
Congenital Deformity		Seizure Disorder - Epilepsy	
Diabetes		Surgery – Serious	
Hearing Loss		Urinary Problem	
Hypertension		Vision	
		Other	

Permission is given this date \_\_\_\_\_, for my child \_\_\_\_\_, to participate in the Health Program at St. Michael's Catholic School, to include EYES, EARS, DENTAL AND TUBERCULIN TESTS, SCOLIOSIS SCREENING, AND GENERAL HEALTH CHECKS. This permission continues in effect until revoked.

Parent's Signature: \_\_\_\_\_