St. Augustine of Canterbury Health History Form

<u>Please Have Physician Fill Out and Sign; Form Must Be On file By the First Day of School</u>

Student Name:______________________________M__F__Date of Birth____________

Please Circle No or Yes and Provide Any Explanation of Medical Conditions:

Hospitalization/Surgery **No** **Yes____**

Asthma: **No** **Yes____**

Food Allergies: **No** **Yes____**

Insect/ Bee Allergies **No** **Yes____**

Seasonal Allergies: **No** **Yes____**

Heart Condition: **No** **Yes____**

Vision Problems: **No** **Yes____**

Wears Glasses/Contacs: **No** **Yes____**

Hearing Disorder: **No** **Yes____**

Diabetes: **No** **Yes____**

Seizure Disorder: **No** **Yes____**

Bleeding Disorder: **No** **Yes____**

Muscular Problem: **No** **Yes____**

Orthopedic Problem: **No** **Yes____**

Headaches/Nose Bleeds **No** **Yes____**

Stomach/GI Problem **No** **Yes____**

Other Conditions **No** **Yes____**

List Medications or Special Dietary Needs____

Student May Participate Fully in all Physical Activities with No Restrictions: Yes No
Explanation of limitations if indicated:____
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Physician Signature____Date_____________