Family Name: ______________________
Grade: __________

Holy Rosary Catholic School
161 9th Street
Idaho Falls, ID 83404
(208) 522-7781 holyrosaryschoolif.org

ANNUAL STUDENT HEALTH AND MEDICAL HISTORY INFORMATION

Student Name: ____ Date of Birth __________________________
Last, First, Middle

Please **check** all ***past*** and ***current*** medical conditions and/or diagnoses, injuries, or services:

Medical Conditions and/or Diagnoses or Injuries	√	Year and Specific Information
Diabetes (student)		
Diabetes (family history)		
Kidney (or other urinary problems)		
Heart Conditions		
Scarlet Fever		
Chicken Pox		
Allergies (to foods or medications, etc.)		
Seasonal Allergies (Hay Fever)		
Asthma		
Seizures		
Concussion/Severe Blow to the Head		
Other Injuries		
Surgeries or Hospitalizations		
Frequent Ear Infections		
Other:		

Does your child wear glasses/contacts? ___yes ___no

Does your child wear hearing aids? ___yes ___no

Any other vision or hearing problems:

Please list ***all*** medications your child is currently taking (name, dosage, and purpose):

*I understand that if my student must take prescribed medication during school hours a medical release form signed by me, my student's doctor, and the principal must be on file at the school. **Initial:_________**

PLEASE COMPLETE THE REVERSE SIDE.

Please **check** all of the services that your child ***has received*** or is ***currently receiving***:

Service	√	**Dates of Service**
Speech/ Articulation Therapy		
Language Therapy		
Education of the Hearing Impaired		
Occupational Therapy		
Physical Therapy		
Counseling Services		
Other:		

List any dietary need or restriction your child has: ____

____

Physician/Pediatrician	**Phone**	**Dentist**	**Phone**

Insurance:____ **Policy#:**_________________________________

***I understand that Holy Rosary School does not assume responsibility for payment of a physician. However, in an emergency, the school may call the physician listed or choose a physician if the one listed is not available.
Initial:________

My child may be given the recommended dose of (check and initial to give permission):

____Acetaminophen and/or ____Ibuprofen

Parent Initials: _____

Was your child attending any Idaho Falls or other area school before enrolling at Holy Rosary?

If yes, WHERE ____ WHEN _________________________________

The above information is accurate, to the best of my knowledge.

____ _______________________

Parent/Guardian Signature *Date*

Mission Statement

Holy Rosary Catholic School's mission is to use its Christian Catholic traditions and community resources to empower and celebrate student achievement, so that our students will have a secure environment in which to grow in their knowledge of God, themselves, community, and academics and use that knowledge to reach their God-given potential.