

**HOLY ROSARY SCHOOL**  
**HEALTH INFORMATION SHEET**

Dear Parents,

The following information is used to promote and protect the health of our students. Please circle "yes" or "no". Fill in the year and specify when applicable.

STUDENT \_\_\_\_\_ M/F \_\_\_\_\_ DOB \_\_\_\_\_ GRADE \_\_\_\_\_  
 ADDRESS \_\_\_\_\_ PARENTS \_\_\_\_\_  
 TODAY'S DATE \_\_\_\_\_

**HISTORY OF PAST AND CURRENT ILLNESSES OR DISABILITY**

<b>ILLNESSES OR DISABILITY</b>	<b>YES/NO</b>	<b>YEAR</b>	<b>PLEASE SPECIFY</b>
Diabetes (student)	YES/NO		
Diabetes (family history)	YES/NO		
Kidney or other Urinary Problems	YES/NO		
Heart Conditions	YES/NO		
Scarlet Fever	YES/NO		
Seizure Disorder	YES/NO		
Concussion/severe blow to head	YES/NO		
Other Injuries	YES/NO		
Chicken Pox	YES/NO		
Allergies	YES/NO		
Hay fever	YES/NO		
Asthma	YES/NO		
Repeated Ear Infections	YES/NO		
Repeated Tonsillitis	YES/NO		
Tonsil Removed	YES/NO		
Handicaps(orthopedic, hearing, vision, etc.	YES/NO		
Other Diseases, health problems, operations	YES/NO		
Hospitalization	YES/NO		
Does student wear glasses/contacts?	YES/NO		
Does student take any medication?	YES/NO		

Doctor \_\_\_\_\_ Dentist \_\_\_\_\_

Has student been in any Idaho Falls or other area schools before? Yes/No \_\_\_\_\_

If yes, WHERE \_\_\_\_\_ WHEN \_\_\_\_\_

Thank you,  
 Elizabeth M. Conrad, B.S, R.N., NBCSN  
 School Nurse