St. Brigid School
Excellence Faith Community

Student Health History Form 2024-2025

Student's name: _____ Preferred name: _____

Grade: _____ Birth date: _____ Male: ☐ Female: ☐

Parent(s) /Guardian(s): _____

Phone: _____ _____

MEDICATIONS

List medications given daily: _____

Reason given: _____

ALLERGIES

☐ None known ☐ Yes, indicate allergies below

	Name/Type	Reaction	Treatment
Animals	_____	_____	_____
Drugs	_____	_____	_____
Environmental	_____	_____	_____
Foods	_____	_____	_____
Bees/wasps	_____	_____	_____

HEALTH HISTORY (Please check all conditions your child has or has had, and explain below)

- ☐ ADD/ADHD
- ☐ Arthritis/joints
- ☐ Asthma
- ☐ Birth defects
- ☐ Blood disorder
- ☐ Bowel problems
- ☐ Cancer
- ☐ Developmental delays
- ☐ Diabetes
- ☐ Hearing problems
- ☐ Heart problems
- ☐ Hepatitis
- ☐ Hospitalizations
- Learning disabilities
- ☐ Menstrual problems
- ☐ Mental Health issues
- ☐ Migraines
- ☐ Physical limitations
- ☐ Relationship issues
- ☐ Seizures or tics
- ☐ Serious illness
- ☐ Skin problems
- ☐ Stomach problems
- ☐ Surgeries
- ☐ Urinary problems
- ☐ Visual problem
- ☐ Other

Please provide addition information (dates, ages, treatments, ongoing care, etc.) :

_____

_____

_____

_____

Parent/guardian signature: _____ **Date**: _____