NOTRE DAME SCHOOL OF DALLAS
HEALTH HISTORY 2019-2020

We are anxious for each child in the Diocese of Dallas to reach their highest potential. In order to realize that goal and assist the classroom teachers in every way that we can, it is necessary to have a continuous health history. Therefore, this form will be sent to you each year for you to complete and return to the school office. Please consult with your school office at any time regarding health issues.

STUDENT'S NAME:_____ _____ DOB: _____
LAST FIRST M.I.

ADDRESS: _____
STREET APT # CITY ZIP

HOME PHONE: _____CELL PHONE: _____

Father's Name:_____ Mother's Name:_____

Place of Business: _____ Place of Business: _____

Business Phone: _____ Business Phone: _____

If your child has had any of the following diseases, please give the date of the occurrence:

_____Diabetes _____Kidney/Bladder _____Chicken Pox _____Other

_____ ADD _____ADHD _____Cancer

Please check any of the following:

_____ Food Allergies List:_____

_____ Glasses/ Contacts Specify: _____

_____ Hearing Impairment Specify: _____

_____ Visual Impairment Specify: _____

_____ Speech Specify: _____

_____ Orthopedic Handicap Specify: _____

_____ Heart Disease Specify: _____

_____ Seizures Specify: _____

_____ Asthma Specify: _____

_____ Hay Fever/Allergies Specify: _____

_____ Prescribed Medications Specify: _____

Additional comments regarding child's health: _____

In the event of an emergency, does the school have permission to take whatever action it deems necessary? ___Yes ___No

In the event of an emergency, if you can not be reached, do you hereby authorize the school and/or its employees to give consent for medical treatment for the above named child? _____Yes _____No If no, what procedure should be taken?

_____

PHYSICIAN'S NAME: _____ Phone: _____

DENTIST'S NAME: _____ Phone: _____

PARENTS' SIGNATURES: _____