

**DIOCESE OF DALLAS
HEALTH HISTORY**

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: _____
_____ Orthopedic Handicap Specify: _____
_____ Heart Disease Specify: _____
_____ Seizures Specify: _____
_____ Asthma Specify: _____
_____ Hay Fever 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: _____