



# OUR LADY OF VICTORY SCHOOL

## Health Information Form

State law requires the information below to be on file in the school office. The law specifically requires immunization for polio, diphtheria, pertussis (whooping cough), rubeola (ten day measles), rubella (three day measles), mumps, and Hepatitis B before a child enters school. We must have written evidence from a physician or health department to verify your child's immunization for these diseases (such as an immunization record/card). Kindergarten or new students are required to provide written evidence of a physical exam. Please complete the Report of Health Examination for School Entry form, included in the registration packet.

Parents are requested to complete the information required below:

Name of student: \_\_\_\_\_ Grade: \_\_\_\_\_ Birth date: \_\_\_\_\_

Gender: Male \_\_\_ Female \_\_\_ Mother's Name: \_\_\_\_\_ Father's Name: \_\_\_\_\_

### Does your child have, or have they had, any of the following diseases or conditions?

	Yes	No	Date		Yes	No	Date
Allergies (complete question 3 below)				Measles – 3 Day			
Asthma				Measles – 10 day			
Chickenpox				Migraine Headaches			
Attention Deficit				Mumps			
Diabetes				Operations			
Epilepsy				Polio			
Heart Condition				Rheumatic Fever			
Hearing Loss				Seizures			
Heart Disease				Tuberculosis			
Injuries				Vision			

**If you have answered yes to any of the above please explain on the back of this sheet.**

1. Please describe any past physical injuries, surgeries or illnesses which might affect your child's performance in school:

\_\_\_\_\_  
\_\_\_\_\_

2. Does your child have any physical limitations that we must be aware of for his/her safety or health?

Yes \_\_\_\_\_ No \_\_\_\_\_ If yes, please describe below:

\_\_\_\_\_  
\_\_\_\_\_

3. Please list any allergies your child has or may have, please also describe severity of allergy: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

4. Is your child currently taking any medication? Yes \_\_\_\_\_ No \_\_\_\_\_ If yes, what medication is he/she taking?

Medication: \_\_\_\_\_ Dosage: \_\_\_\_\_

The condition for taking the medication: \_\_\_\_\_

When was his/her last physical examination? Doctor: \_\_\_\_\_ Date: \_\_\_\_\_