ST. PAUL LUTHERAN SCHOOL | LAKE MILLS, WISCONSIN

HEALTH HISTORY

To be filled out for grades K, 3, 7

Student Name____Grade___________________

Dear Parents and Students: In order to update our school health records and to become aware of any health concerns, we request that you complete this questionnaire. Additional information or comments are also welcome. Should your child have a medical problem during the school year please notify the school. The following screening programs will be conducted this year:

Vision - Grades Kindergarten, 1,3,5,7
Hearing - Grades Kindergarten, 1

Parents will be notified only if screening results indicate the student should be seen by a physician; other results are available on request. Parents of students who are not scheduled to be screened may request a screening by calling the school office.

Please indicate which of the following apply to your child. If checked, please explain.

Stomach ulcer ______________________
Rheumatic Fever ___________________________________
Hemophilia ____
Hepatitis ____
Birth defects ______________________________________
Orthopedic problems ________________________________
Emotional problems _________________________________
Scoliosis ___________________________
Eating / Nutritional problems ___________________________

EYES

Is or was cross-eyed
Wears glasses
Wears contacts
Any vision loss
Any eye surgery
Any other eye problem (explain)

Skin rashes___________________________
Bedwetting ___________________________
Operations______________________________
Accidents_____________________________
Injuries_______________________________
Diseases & conditions which may affect their education______________________________
Headaches/Migraines_____________________
Bladder disorders________________________

EARS

Frequent infections
Any ear surgery has
hearing loss has
hearing aid Tubes in
ears
Any other ear problem (explain)

Is your child taking medication? __________ Why? ____
Name of drug _______________________________During school hours ________ Only at home ________

If during school hours, please fill out a Medication Form and have your doctor sign it.

If there are any limitations on your child's activities at school, please list them and the reasons for the limitations below. If so, a dated note from the student's physician should state the reason, the amount of activity permitted, and the length of time this is to be in effect. ____

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Pertinent updated health information on your child will be shared with school personnel for the safety and well- being of your child. I give permission to have my child participate in the school screening programs vision and hearing.

Parent's signature____Date_______________________________