STUDENT HEALTH FORM
PRESCHOOL THROUGH TWELFTH GRADE

Fax 317-858-2819
(PreK-6) 317-858-2820
(Upper School) 317-858-2823

Please complete the following information which will be made available to the school personnel.
Please relate any appropriate concerns that may affect a student's learning abilites to the principal and the applicant's teacher(s).

Name of Student ______________________________ Date of Birth ______________
Last First Middle

Father's Name ______________________ Mother's Name ______________________

Current Physician ______________________ Office Number ______________________

Current Dentist ______________________ Office Number ______________________

Has the applicant been diagnosed with ADD or ADHD? ☐ Yes ☐ No

Has the applicant been diagnosed with a learning disability? ☐ Yes ☐ No If yes, please explain ______________

Has the applicant been diagnosed with a physical disability? ☐ Yes ☐ No If yes, please explain ______________

HEALTH CONDITIONS (Please check if any of the following apply to your child).

______ Abnormal Spinal Curvature
______ Allergies or hay fever
______ Anemia
______ Arthritis
______ Asthma
______ Behavior Problems
______ Birth or Congenital Malformation
______ Malformation
______ Cancer, Type ______
______ Chicken Pox
______ Constipation (frequent)
______ Cystic Fibrosis
______ Diabetes
______ Diarrhea (frequent)
______ Eczema
______ Emotional Problems
______ Headaches (frequent)
______ Heart Disease
______ Hepatitis (circle) A B C
______ Kidney Disease
______ Learning Disability
______ Meningitis or Encephalitis
______ Seizures/Epilepsy
______ Sickle Cell Disease
______ Skin Rashes (frequent)
______ Stool Soiling
______ Throat Infections (frequent)
______ Tics/Nervous Twitches
______ Urinary Tract Infections
______ Wetting (daytime/nighttime)
______ Other (Please list)
____
____

If you checked any of the above, please explain. ______________________________

Date of last tetanus shot ______________ Does your child wear glasses or contact lenses? ☐ Yes ☐ No

Does your child have frequent ear infections? ☐ Yes ☐ No Has your child had any loss of hearing? ☐ Yes ☐ No

Does your child have any known allergies? ☐ Yes ☐ No If yes, please explain type and reaction. ______________

Has your child had any severe injuries or illnesses? ☐ Yes ☐ No If yes, please explain. ______________

Has your child been hospitalized or had any surgeries? ☐ Yes ☐ No If yes, please explain. ______________

Is the student presently taking any medication? ☐ Yes ☐ No If yes, please list name(s) of medication(s). ______________

Dosage ______________ Milligrams ______________ Frequency/day ______________