

St. Clement School  
790 Calhoun St.  
Hayward, CA 94544  
510-538-5885

## STUDENT MEDICAL HISTORY

(To be completed by the parent)

Student's Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

Grade: \_\_\_\_\_

### HEALTH HISTORY:(please check the conditions were appropriate)

- |   |                         |                                |
|---|-------------------------|--------------------------------|
| ___ Allergies - please list: _____        |                         |                                |
| ___ Asthma _____                          |                         |                                |
| ___ Allergy to drugs – please list: _____ |                         |                                |
| ___ Appendectomy                          | ___ Measles             | Dental History                 |
| ___ Cerebral Palsy                        | ___ Mumps               | ___ Dental ridge               |
| ___ Concussion                            | ___ Nervousness         | ___ False Teeth                |
| ___ Defective Vision                      | ___ Persistent Cough    | ___ Orthodontia                |
| ___ Diabetes                              | ___ Poliomyelitis       |                                |
| ___ Dizziness/Blackouts                   | ___ Recurrent Boils     |                                |
| ___ Hearing Loss                          | ___ Rheumatic Fever     |                                |
| ___ Epilepsy                              | ___ Rubella (3-day)     |                                |
| ___ Freq. Headaches                       | ___ Scarlet fever       |                                |
| ___ Freq. Leg or Joint pain               | ___ Shortness of Breath |                                |
| ___ Freq. Nosebleeds                      | ___ Sinus Trouble       |                                |
| ___ Heart Disease                         | ___ Speech Difficulty   |                                |
| ___ Hernia (Rupture)                      | ___ Tires Easily        |                                |
| ___ Kidney Disease                        | ___ Tonsillectomy       |                                |
| ___ Lameness                              | ___ Tuberculosis        |                                |
|   | ___ Wears Glasses       | ___ reading only    ___ always |

Please list any other serious illnesses, operations or injuries that your child had and the age when this occurred \_\_\_\_\_

Has your son/daughter had contact with someone with tuberculosis? \_\_\_yes, \_\_\_no

If yes, with whom \_\_\_\_\_

Last contact date \_\_\_\_\_

Has your child ever been advised not to participate in competitive athletics? \_\_\_yes, \_\_\_no

If yes please state the reason why \_\_\_\_\_

Adjustments: Do you feel that your son/daughter has problems of adjustment to friends, school, or to family that should be brought to the attention of your physician or the school personnel?

\_\_\_yes, \_\_\_no

Comments: \_\_\_\_\_

Parent/Guardian Signature \_\_\_\_\_

Date: \_\_\_\_\_

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