St. Mark School
Health Questionnaire-Confidential

Child's Name: ___________________________ Date of Birth: ___________________

Address ____________________________________ Home Phone ________________

School last attended ____________________________ City _____________________

Father's Name: ____________________ Alternative Phone_______________

Mother Name: ____________________ Alternative Phone_______________

Guardian(s) ____

Name of Family Physician: _________________________ Phone_____________

Name of Family Dentist: ___________________________ Phone_____________

Health History: Please check YES or NO for the following. If yes, give dates.

	NO	YES	DATE		NO	YES	DATE
Chicken pox	____	____	______	Diabetes	____	____	______
Measles	____	____	______	Tubes in ears	____	____	______
Mumps	____	____	______	Heart Problems	___	____	______
Whooping Cough	____	____	______	Scoliosis	____	____	______
Tuberculosis	____	____	______	Epilepsy	____	____	______
Asthma	____	____	______	Fracture	____	____	______
Meningitis	____	____	______	Wears Glasses	____	____	______

Allergies ______Y ______N

Medicines: _______________ **Foods:** ________________ **Other:** _____________

Medications currently taking: ____

Parent Printed Name______________________

Parent Signature__________________________ **Date**______________