SUSSEX CHRISTIAN SCHOOL

Challenging the Mind, Strengthening the Spirit

STUDENT HEALTH HISTORY FORM

Name:_____ Date of Birth:_____

Parent's/Guardian Name:_____

	Yes	No
Allergies		
Anemia		
Asthma		
Bedwetting		
Bowel Problem		
Cancer		
Chicken Pox		
Concussion		
Congenital Disability		
Convulsive Disorder		
Dental Problems		
Developmental Delay		
Diabetes		
Drug Sensitivities		
Ear Problems		
Headaches		
Heart Disease		
Hepatitis		

	Yes	No
High Fevers		
Hospitalization		
Learning Disability		
Mental Disorder		
Murmur		
Mononucleosis		
Neuromuscular Disorder		
Operations		
Pneumonia		
Rheumatic Fever		
Skin Problems		
Speech Problems		
Stomach Problems		
Strep Infections		
Unconsciousness		
Urinary Problems		
Significant Injuries		
Other:_____		

Is your child currently taking any medication or therapy? ( )Yes ( )No
If "yes", please indicate type, dose, reason, and duration:

_____

_____

Signature of Parent/Guardian:_____ Date:_____