

# St. Mary's Academy Health Form

Student's Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Place of Birth: \_\_\_\_\_

Address: \_\_\_\_\_

Family Name: \_\_\_\_\_

Phone: \_\_\_\_\_ (Home) \_\_\_\_\_ (Work)

Immunization record provided? \_\_\_\_\_

## Health History:

Allergies? (Please state) \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

List any other disease contracted, give dates:

\_\_\_\_\_  
\_\_\_\_\_

Is there a physical condition or medical history of which the school should be aware? (i.e. surgery)

\_\_\_\_\_  
\_\_\_\_\_

Family Physician: \_\_\_\_\_ Family Dentist: \_\_\_\_\_

In an emergency, when a parent/guardian cannot be reached, I give my permission for the school to use a physician other than our family physician.

Parent/Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_