HEALTH QUESTIONNAIRE AND PERMISSION FOR TESTING PROGRAMS

PUPIL ______________________________
Last Name First Middle

Birth Date ____________ Grade ____________

Father or Guardian ______________________________
Last Name First Middle

Home Address ______________________________

Home Phone No. ______________________________

	Phone No.
Father's Place of Employment:	
Mother's Name:	
Place of Employment:	
Physician:	
Hospital Preference:	
Dentist:	

Illness	Date
Chicken Pox	
Diphtheria	
German Measles	
Mumps	
Whooping Cough	
Poliomyelitis	
Scarlet Fever	
Smallpox	
Typhoid Fever	
Pneumonia	
Ear Infections	
Tonsillitis	
Epilepsy	
Injuries	
Surgery	
Diabetes	
Allergy	
Tuberculosis	
Rheumatic Fever	
Measles	
Serious Injuries	
Head	
Back	
Etc.	

If your child is on medication prescribed by your doctor, please ask your doctor for an order for same, as we are not permitted to give medication of any kind, including aspirin, without an order form from your doctor

IMMUNIZATION DATES

VACCINE	2 mos.	4 mos.	6 mos.	15 mos.	12 -18 mos.	4 - 6 yrs.	14 -16 yrs.	Every 10 yrs.
DPT or TD								
POLIO								
MEASLES								
MUMPS								
RUBELLA								
SMALLPOX (Optional)								
TUBERCULIN TEST (Date)								

PERMISSION FOR TESTING PROGRAMS

Permission is given this date ____________, for my child ____________ ____________ to participate in the Health Program at Sacred Heart School, to include EYES, EARS, DENTAL AND TUBERCULIN TESTS, SCOLIOSIS SCREENING, AND GENERAL HEALTH CHECKS. This permission continues in effect until revoked.

Parent or Guardian Signature ______________________________

(Form HQ-2)
Revised: 8/79