# Lakewood Catholic Academy
# HEALTH QUESTIONNAIRE – CONFIDENTIAL

This form must be completed by a parent and returned to the school office. State Law requires all children to be immunized. **Please attach a copy of your child's immunization record signed by their physician.** Children will be excluded from school if immunizations are not obtained by the 15th day of school.

**Child's Name:** _____ **Grade**: _____

Address: _____ Home Phone # _____

Child's Physician _____ Phone # _____

Child's Dentist: _____ Phone # _____

Date of Birth: _____ Last School Attended _____

Mother's Name: _____ Work #_____

Father's Name: _____ Work #_____

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

| | NO | YES | DATE | | NO | YES | DATE |
|---|---|---|---|---|---|---|---|
| Chicken pox | ____ | ____ | _____ | Meningitis | ____ | ____ | _____ |
| Regular Measles | ____ | ____ | _____ | Tubes in ears | ____ | ____ | _____ |
| German Measles | ____ | ____ | _____ | Strep Throat | ____ | ____ | _____ |
| Mumps | ____ | ____ | _____ | Heart Problems | ____ | ____ | _____ |
| Whooping Cough | ____ | ____ | _____ | Scoliosis | ____ | ____ | _____ |
| Diphtheria | ____ | ____ | _____ | Diabetes | ____ | ____ | _____ |
| Rheumatic Fever | ____ | ____ | _____ | Epilepsy | ____ | ____ | _____ |
| Scarlet Fever | ____ | ____ | _____ | Surgery | ____ | ____ | _____ |
| Tuberculosis | ____ | ____ | _____ | Fracture | ____ | ____ | _____ |
| Polio | ____ | ____ | _____ | Wears Glasses | ____ | ____ | _____ |
| Asthma | ____ | ____ | _____ | Hearing Problem | ____ | ____ | _____ |

**Allergies:** _____Y _____N
**Medicines:** _____ **Foods**:_____
**Other:**_____

_____ _____ _____
**PARENT SIGNATURE** **PARENT PRINTED NAME** **DATE**