ARLINGTON CATHOLIC HIGH SCHOOL HEALTH RECORD

Date_____ Year of Graduation_____

Name_____ Date of Birth_____

Part A: To be Completed by Parent/Guardian

Allergies (Medication/ Food) _____

Has your child ever had any of the following? Please circle yes/no and explain

Y	N	Condition	Date	Explanation
Y	N	Asthma/Allergies		
Y	N	Heart Condition		
Y	N	Diabetes		
Y	N	Kidney Disease		
Y	N	Blood Disorder		
Y	N	Mononucleosis		
Y	N	Hepatitis		
Y	N	Head Injury/Concussion		
Y	N	Seizure		
Y	N	Hearing Disorder		
Y	N	Vision Disorder/Glasses		
Y	N	Fainting		
Y	N	Fractures/Sprains		
Y	N	Menstrual Problems		

Current Medications(Name/Dose/Times)