Aurora Waldorf School
Health History Form

STUDENT NAME_____ HOME PHONE_____

STUDENT ADDRESS_____

BIRTHDATE_____ BIRTHPLACE_____

PARENT #1 NAME_____ WORK/CELL PHONE_____

PARENT #1 ADDRESS_____ HOME PHONE_____

PARENT #2 NAME_____ WORK/CELL PHONE_____

PARENT #2 NAME_____ HOME PHONE._____

PHYSICIAN TO BE CALLED IN EMERGENCY_____ PHONE._____

ATTEND AURORA WALDORF SCHOOL IN PAST? YES NO

PREVIOUS SCHOOL _____ ADDRESS._____

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PLEASE LIST ANY ILLNESSES OR INJURIES THAT YOUR CHILD HAS HAD, AND PROVIDE ADDITIONAL INFORMATION, FOR FURTHER CLARIFICATION IN THE SPACE BELOW.

ILLNESS	**DATE**	**ILLNESS**	**DATE**
ALLERGIES	_____	OPERATIONS	_____
ANEMIA	_____	PNEUMONIA	_____
ASTHMA	_____	RHEUMATIC FEVER	_____
CHICKENPOX	_____	SCARLET FEVER	_____
CONTACT WITH TB	_____	SEIZURE DISORDER	_____
DIABETES	_____	SERIOUS INJURY	_____
EAR CONDITIONS	_____	TUBERCULOSIS	_____
FRACTURES	_____	WHOOPING COUGH	_____
HEART DISEASE	_____	VISUAL DISORDERS	_____
KIDNEY DISEASE	_____	OTHER	_____
NEUROLOGICAL CONDITIONS	_____		

PLEASE LIST ANY INFORMATION THAT SHOULD BE BROUGHT TO THE ATIENTION OF THE NURSE/SCHOOL.

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SIGNATURE OF PARENT/GUARDIAN,_____ DATE._____