



**MATER DEI CATHOLIC HIGH SCHOOL  
HEALTH HISTORY**  
(To be completed by parent and / or guardian)

**Student Name:** \_\_\_\_\_ **Grade** \_\_\_\_\_ **Age:** \_\_\_\_\_ **Year: 2012/2013**  
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Date of Birth: \_\_\_\_\_ Place of Birth: \_\_\_\_\_ Sex: M \_\_\_\_\_ F \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Home Phone: (\_\_\_\_) \_\_\_\_\_ Parents E-Mail \_\_\_\_\_

Father/Guardian: \_\_\_\_\_ Work Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

Mother/Guardian: \_\_\_\_\_ Work Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_  
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**Health Problems**

**Facts to know in case first aid treatment is necessary, such as bee sting, allergy, diabetes, etc.**

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**Vision Difficulty**

\_\_\_\_\_

**Wears Glasses/Contacts**

\_\_\_\_\_

**Hearing Difficulty**

\_\_\_\_\_

**Speech**

\_\_\_\_\_

**Emotional**

\_\_\_\_\_

**Bones or Joints**

\_\_\_\_\_

**Convulsions of Fainting**

\_\_\_\_\_

**Diabetes**

\_\_\_\_\_

**Allergies (Asthma)**

\_\_\_\_\_

**Other**

\_\_\_\_\_

**Other**

\_\_\_\_\_

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**For School File**

**Attach To Health Records**

**Mater Dei Catholic High School  
1615 Mater Dei Drive  
Chula Vista, Ca 91913  
(619) 423-2121 Ext. 115**