St. Joseph
CATHOLIC SCHOOL
GRADES PreK - 5

St. Joseph Maumee Preparatory
A MIDDLE SCHOOL PARTNERSHIP WITH CENTRAL CATHOLIC HIGH SCHOOL

HEALTH HISTORY

Child's Name _____ **Date of Birth** _____ **Age** _____ **Gender** _____

Address _____

Parent/Guardian _____ / _____
Mother Father

With whom does child live _____

Physician _____
Name Address Phone

Dentist _____
Name Address Phone

HEALTH CONDITIONS: ***please check and specify where applicable.***

- ☐ ADD/ADHD _____
- ☐ Asthma _____
- ☐ Behavior Concerns _____
- ☐ Blood problems _____
- ☐ Diabetes _____
- ☐ Hearing _____
- ☐ Heart _____
- ☐ Seizure Disorder _____
- ☐ Special Diet _____
- ☐ Vision (contacts, glasses) _____

Please list any additional health information: _____

CHILDHOOD DISEASE, ILLNESS OR INJURY

Event	Age	Hospitalized

ALLERGIES: ***please list and describe***

Medicine/drugs _____

Foods _____

Other _____

ADDITIONAL INFORMATION:

What medications are given daily and reason? _____

What medications are given frequently, but not daily and reason? _____

Do you have other comments or concerns about this child's health, development, behavior, family or home life that you feel the school should be aware of? If yes, explain briefly. _____

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(OVER)

HEALTH HISTORY
continued

Child's Name _____

Form completed by _____

DPT *1._____ *2._____ *3._____ *4._____ *5._____

POLIO *1._____ *2._____ *3._____ *4._____ *5._____

MMR *1._____ *2._____

HEPATITIS B *1._____ *2._____ *3._____ *4._____

VARICELLA *1._____ 2._____

HIB *1._____ *2._____ *3._____ *4._____

PREVNAR 1._____ 2._____ 3._____ 4._____

OTHER Type _____ Date _____ Type _____ Date _____

PHYSICIAN REPORT
Screening Test

VISION

Distance Acuity	R_____	L_____
Muscle Balance	pass_____	fail _____
Stereopsis	pass_____	fail _____
Color	pass _____	fail _____
Child wears glasses?	yes_____	no_____
Referral made?	yes_____	no_____

HEARING

Pure tone (pass/fail)	R_____	L_____
Child wears a hearing aid	yes___	no___
Child sees hearing specialist	yes___	no___
Referral made	yes___	no___

PHYSICAL EXAMINATION: Essentially normal _____ Abnormalities as follows:_____

_____

_____

Is this child able to participate in all school activities? Yes _____ No _____ (Please explain)_____

_____

Date of exam _____

Physician signature _____

Address _____

Phone _____