DIFFERENT BY DESIGN. Catholic SCHOOLS

St. Joseph CATHOLIC SCHOOL

2016-2017 School Year

Dear Parent/Guardian,

At the start of the school year I will need to create/update your student's medical file. Health history and physical exam are required for Pre-school and Kindergarten. New students need to provide health history. Immunization documentation should be current for ALL STUDENTS. Please send in information regarding any changes in your child's health history from the previous school year.

I have attached forms required by the State of Ohio including:

1. **Health History** (to be completed by parent/guardian)
   Please be sure to provide name and number for both PHYSICIAN and DENTIST.
2. **Physical Exam Report** (to be completed by your child's **physician)**
3. **Immunization Documentation**
   These are the vaccination requirements per Ohio Law:

PRESCHOOL:

- **4 doses of DTaP, DTP or DT** *of any combination.*
- **3 doses of OPV or IPV** *of any combination.*
- **1 dose of MMR** *on or after first birthday*
- **3 or 4 doses of HIB** *or one dose if given on or after 15 months of age.* ***Last dose must be after one year of age.***
- **3 doses of Hep B** ***last does must be after age 6 months.***
- **1 dose of Varicella** *on or after first birthday.*

KINDERGARTEN:

- **5 doses of DTaP, DTP or DT** *of any combination.* ***Last dose must be after 4th birthday.***
- **3 or 4 doses of IPV** ***last dose must be after 4th birthday.***
- **2 doses of MMR** ***first dose on or after first birthday.***
- **3 doses of Hep B** ***last dose must be after age 6 months.***
- **2 doses of Varicella** ***first dose on or after first birthday.***

7TH GRADE STUDENTS:

- **Tdap booster**
- **Meningococcal vaccine**

If your child has any medical issues or concerns please let me know. If you have any questions regarding any of the forms I can be reached via email mary.gies@stjosephmaumee.org or in the health office at (419) 893-7243. I am in the office M, T, W, F 10-2 and Thursday 9:30-1:30 during the school year.

Mary Gies, RN, BSN, LSN
St. Joseph School Nurse

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. ______________________________________

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 ____________________