

Saint Charles School Health History

02/2012

STUDENT NAME _____ **Date of Birth** _____

MEDICAL HISTORY

Has your child ever had the following?

- | | | |
|--|---|--|
| <input type="checkbox"/> Measles | <input type="checkbox"/> Pneumonia | <input type="checkbox"/> Whooping Cough |
| <input type="checkbox"/> Rubella | <input type="checkbox"/> Meningitis | <input type="checkbox"/> Diphtheria |
| <input type="checkbox"/> Mumps | <input type="checkbox"/> Scarlet Fever | <input type="checkbox"/> Polio |
| <input type="checkbox"/> Fracture of any bones | <input type="checkbox"/> Severe Head Injury | <input type="checkbox"/> Rheumatic Fever |
| <input type="checkbox"/> High Fevers | <input type="checkbox"/> Frequent Strep | <input type="checkbox"/> Frequent Ear Infections |
| <input type="checkbox"/> Chicken Pox When? | <input type="checkbox"/> Throat Infections | <input type="checkbox"/> Tubes R____ L____ |
| <input type="checkbox"/> Skin Rashes, etc. | | |

Does your child have or has your child had the following?

- | | | |
|---|--|---|
| <input type="checkbox"/> Asthma* | <input type="checkbox"/> Hay Fever/Allergies | <input type="checkbox"/> Known Scoliosis |
| <input type="checkbox"/> Frequent Ear Infections | <input type="checkbox"/> Hearing Problems | <input type="checkbox"/> Tics/Nervous Twitches |
| <input type="checkbox"/> Frequent Cold/Sinus Infections | <input type="checkbox"/> Convulsions | <input type="checkbox"/> Allergies to: Food _____ |
| <input type="checkbox"/> Heart Disorder | <input type="checkbox"/> Seizures | <input type="checkbox"/> Medicine _____ |
| <input type="checkbox"/> Diabetes* | <input type="checkbox"/> Kidney disorder | <input type="checkbox"/> Autism Spectrum Disorder |
| <input type="checkbox"/> Bladder Disorder/Bed Wetting | <input type="checkbox"/> Visual Problems (Corrected by Glasses or Surgery) | |
| <input type="checkbox"/> ADD/ADHD | <input type="checkbox"/> Aspergers | |

Please be specific about these allergies _____

***Please fill out emergency action plan available from the school nurse.**

Please note any other serious illnesses, operations, or injuries and the age incurred:

Were there any complications during surgery? Yes No

Comments: _____

Is your child on any medication? Is it given daily? What is it for? _____

Does your child wear glasses _____ Contact Lenses _____

Are there comments or concerns about your child's health, development, behavior or family/home life you would like to share with the School? If so, please explain _____

Is your child: _____ very active _____ normally active _____ inactive

Date of Last Physical Exam _____ Date of Last Dental Exam _____

Effective Fall 2010, Ohio law now requires that every Kindergarten or first grade student entering school **MUST** have 2 varicella/chicken pox as well as the other required immunizations (5 DPT and booster, 4 Polio, 3 Hep B, and 2 MMR) by day 14 of school or they cannot attend until up-to-date. Grades 2-6 students need only 1 varicella. Grade 7 students need Tdap or Td booster.

Signature of Parent/Guardian and Date _____