St. Albert the Great School

STUDENT HEALTH INFORMATION AND IMMUNIZATION RECORD

Preschool, kindergarten and new students

SECTION I – HEALTH RECORD and HISTORY- completed by parent/guardian

Student's Name: ______________________________
Last *First* *Middle Initial*

Student's Date of Birth: __________ Grade: __________ Male ____ Female ____

Name of Parent (s) or Guardian ______________________________

INSTRUCTIONS- parent, please answer questions 1-7 below and sign.

1. Birth and Developmental History: ☐ **No unusual birth or developmental history**

Did the mother have any unusual physical or emotional illness during this pregnancy? ☐YES ☐NO
Was infant born full term? ☐YES ☐NO Did the infant have any sickness or problems? ☐YES ☐NO

Briefly explain illness or problems:

____

How does the child's development compare to other children, such as his or her brothers/sisters or playmates?

☐About the same ☐delayed ☐Advanced

2. Review the conditions/concerns below and circle YES or NO as it applies to your child:

Asthma/wheezing/reactive airway	YES	NO	Ear/hearing problems	YES	NO
Diabetes	YES	NO	Wears a hearing aid	YES	NO
Heart disease	YES	NO	Frequent ear infections	YES	NO
Cancer or history of cancer	YES	NO	Difficulty producing sounds	YES	NO
History of chickenpox	YES	NO	Currently enrolled in speech therapy	YES	NO
ADHD/ADD	YES	NO	Difficulty being understood by others	YES	NO
Fears/anxiety	YES	NO	Difficulty hearing/understanding directions	YES	NO
Tires easily	YES	NO	Dental concerns	YES	NO
Eye/vision problems	YES	NO	Frequent bathroom use	YES	NO
Wears glasses/contacts	YES	NO	Physical limitations or disability	YES	NO
Born premature? How many weeks?	YES	NO	Serious illness, injury, or surgery	YES	NO
Currently under a doctor's care?	YES	NO	Currently taking medications or food supplements	YES	NO

If you circled **YES** above, please explain: ______________________________

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3. **Does your child have any allergies to medications, foods, insects or inhalants?** ☐ YES ☐ NO
If yes, please explain and describe reaction: ____________________

4. **Will your child require medication at school?** ☐ YES ☐ NO

5. **Would you say your child is:** ☐ very active ☐ average ☐ quiet

6. **Please state any other health history or medical information that school personnel should be aware of:**

____

7. **Date of last physical exam:** _______ **Date of last dental exam:** _______ **Date of last eye exam:** _______

Signature of Parent______________________________ **Date**______________

SECTION II- RECORD OF IMMUNIZATION- Completed by Health Care Provider or Clinic

Student's Name:

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Last *First* *Middle Initial* *Date of Birth*

You may attach immunization record with current provider signature/date or complete the information below. Please include **month, date and year** for each required dose. Immunizations are required by the Ohio Revised Code 3313.67 and are ***to be on file with the school within 14 days of school entry.***

Vaccine	Dose 1	Dose 2	Dose 3	Dose 4	Dose 5	Dose 6
DPT (DTaP, DT, DT, Tdap, Td)						
Polio (IPV)						
Measles, Mumps, Rubella (MMR)						
Varicella (Chickenpox)						
Hepatitis B (HBV or Hep B)						
Hepatitis A						
HIB (Haemophilus Influenza type b)						
Pneumococcal Conjugate						
Influenza- if seasonal flu vaccine available						
MCV 4 (Meningococcal) for **7th and 12th** grade ONLY						

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Print Licensed Medical Provider Name or stamp

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Address

____
Phone

Licensed Medical Provider or Clinic Signature/Date:______________________ **Date of last physical exam:**_________

Revised 1/2020