St. Aloysius Catholic School
Ohio School Health History
(to be completed by parent or guardian)

Child's Full Name ______________________________ Male______ Female______
Last First Middle

Date of Birth______________

Child's Address______________________________ Phone______________________

With whom does your child live? ______________________________
Name Relationship

Who is this child's legal guardian? ______________________________
Name

Father's Name______________________________
Address (if different from child)______________________________
Home Phone____________ Occupation______________________ Work Phone____________

Mother's Name______________________________
Address (if different from child)______________________________
Home Phone____________ Occupation______________________ Work Phone____________

Family History:

Please list this child's brothers and sisters

Name	Birth Year	Sex	Name	Birth Year	Sex
1. ______	______	______	4. ______	______	______
2. ______	______	______	5. ______	______	______
3. ______	______	______	6. ______	______	______

Is any language other than English spoken in the home? If so, what language? ______________________________

Has this child attended play class/preschool? __________ Where? ______________________________

Has your child had speech therapy? __________ Where? ______________________________

Perinatal History:

Did the mother have and unusual or emotional illness during this pregnancy? _______ yes _______ no
If yes, explain briefly: ______________________________

How old was the mother when the child was born? ______ Was the infant? ____ full term _____ early _____ late

Did this child as an infant have any sickness or problems? _____ yes _____ no
If yes, explain briefly: ______________________________

Developmental History:

* Please give the approximate age at which this child:
________Walked alone ________ Spoke in sentences ________Toilet Trained ________ Dressed self

* How does this child's development compare to other children, such as a brothers/sister or playmates?
________About the same ________ Delayed ________ Advanced

Behavioral History:

* The child is usually: ________Very active ________ Normally active ________ Rather inactive

* Has your child ever been violent or acted out in the following manner towards adults or other children?
________ Hitting ________ Kicking ________ Biting ________Fighting ________Scratching
* Do you have any concerns about how your child gets along with other children? ________Yes ________ No
  If yes, explain briefly: ____

* Is this student enrolled in special education courses? ________yes ________no

* Please add any comments or concerns you have about your child's health, development, behavior, family, or home life that you would like the school to be aware of: ____
____
____

IMMUNIZATION RECORD

Type	**Dates**				
DTP, DT, DTaP	___/___/___	___/___/___	___/___/___	___/___/___	___/___/___
Polio, OPV, or IVP	___/___/___	___/___/___	___/___/___	___/___/___	___/___/___
MMR (combined)	___/___/___	___/___/___			
Hepatitis B (3)	___/___/___	___/___/___	___/___/___		
HIB (not required)	___/___/___	___/___/___	___/___/___		
Varivax (Chicken Pox)	___/___/___				
Other (Identify) ____________________	___/___/___				

HEALTH CONDITIONS

Please check any that this child has had:

__ Abnormal spinal curvature (Scoliosis)
__ Allergies of hay fever
__ Anemia
__ Arthritis
__ Asthma or wheezing
__ Bedwetting at night
__ Behavior problem
__ Birth or congenital malformation
__ Cancer, type ___________________
__ Chicken pox
__ Chronic diarrhea or constipation
__ Color blindness in family
__ Concern about relationship with siblings or friends
__ Cystic fibrosis
__ Diabetes
__ Eczema
__ Emotional problems
__ Frequent headaches
__ Frequent skin infections
__ Frequent sore throat infections
__ Heart disease, type _______________
__ Hepatitis
__ Kidney disease, type ______________
__ Meningitis or encephalitis
__ Multiple ear infections (3 or more)
__ Mumps
__ Near drowning or near suffocation
__ Nervous twitches or ticks
__ Poisoning
__ Poor hearing
__ Pregnancy
__ Rheumatic fever
__ Seizures or epilepsy
__ Sickle cell disease
__ Stool soiling
__ Substance abuse (alcohol, drugs)
__ Suicide attempt
__ Urinary tract infection
__ Wears glasses
__ Wetting during day

ALLERGIES –
Medicines/drugs ______________________________

If so, describe Reaction: ______________________________

Foods/plants/animals/other ______________________________

If so, describe Reaction: ______________________________

MEDICATIONS-
Is the child on any medication?

Name/Dosage ____________________ Reason ____________________

Name/Dosage ____________________ Reason ____________________

Name/Dosage ____________________ Reason ____________________

Name/Dosage ____________________ Reason ____________________

Do you have any other comments or concerns about your child that you would like the school to be aware of?

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INJURIES AND ILLNESSES

Injury/Illness	Age	Hospitalized?

Completed by ______________________________

Name Relationship