St. Rose School
217 E. Front St.
Perrysburg, OH 43551
419-874-5631

Health History

Child's name _____ Birth date _____ Male ____ Female ____

Mother's name: _____ Phone # _____

Father's name: _____ Phone # _____

With whom does the child live? _____ Legal Guardian(s)? Yes / No

Perinatal / Developmental History

Birth weight _____ Full term _____ Premature _____ Illness/problems in the nursery _____

Please give the approximate age of your child:

Walked alone _____ Toilet trained _____ Dressed self _____ Spoke in sentences _____

How does development compare to siblings or playmates? Same _____ Slower _____ Faster _____

Medical History

1. Health Conditions (i.e. asthma): _____
2. History of Hospitalization: _____
3. Allergies (food/plant/drug): _____
4. Childhood Diseases (i.e. chicken pox): _____
5. Medications (taken on a regular basis): _____

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

_____

Completed by _____ (relationship) _____ Date _____

Dentist Report

Dentist _____

Address _____

Phone _____

St. Rose School Health Record (Cont.)

Physician's Report

Child's Name: _____ Age: _____ (years) _____ (mos.)

Immunizations: (Pre-Kindergarten) 4 DPT, 3 Polio, 1 MMR, 3 Hepatitis B, & 4 HIB
(Kindergarten) 5 DPT, 4 Polio, 2 MMR, 3 Hepatitis B, 2 Varicella

DPT	1. _____	2. _____	3. _____	4. _____	5. _____
Polio	1. _____	2. _____	3. _____	4. _____	5. _____
MMR	1. _____	2. _____			
Hep B	1. _____	2. _____	3. _____		
HIB	1. _____	2. _____	3. _____	4. _____	
Varicella	1. _____	2. _____			
Other	Type _____	date _____	Type _____	date _____	

Screening Tests:

Vision (pass / fail):
Distance Acuity R _____ L _____
Muscle Balance R _____ L _____
Farsightedness R _____ L _____
Color (Circle) Pass / Fail
Wears glasses Yes / No
Referral mad Yes / No

Hearing (pass / fail)
Pure Tone R _____ L _____
Impedance R _____ L _____
Frequent ear infections? _____
Does child have tubes? _____
Right _____ (date(s) placed)
Left _____ (date(s) placed)

Physical Exam:

Essentially normal: _____ Abnormalities as follows: _____

_____

Is this child able to participate in all school activities? Yes _____ No _____

If no, please explain: _____

This is to certify that the above named student has been seen in our office and is in suitable condition to attend a preschool or kindergarten program.

(PRINT OR STAMP BELOW)

Signature _____ Physician Name _____

Date of Exam: _____ Address _____

Phone: _____ _____