# 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?

______________________________

______________________________

**INJURIES AND ILLNESSES**

| Injury/Illness | Age | Hospitalized? |
| --- | --- | --- |
| ____________ | ______ | ______ |
| ____________ | ______ | ______ |
| ____________ | ______ | ______ |

Completed by ______________________________

Name Relationship