

St. Albert the Great School
STUDENT HEALTH INFORMATION AND IMMUNIZATION RECORD
 Preschool, kindergarten and new students

SECTION I – HEALTH RECORD- completed by parent/guardian

Student's Name: _____

Student's Date of Birth: _____ Grade: _____ Male _____ Female _____

Name of Parent (s) or Guardian _____

INSTRUCTIONS- parent, please answer questions 1-6 below and sign.

1. 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: _____

2. Does your child have any allergies to medications, foods, insects or inhalants? YES NO

If yes, please explain and describe reaction: _____

3. Will your child require medication at school? YES NO

4. Would you say your child is (circle one): very active average quiet

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

6. 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:

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 grade ONLY						

Mantoux/PPD test (required ONLY for foreign exchange students and students from another country)

Date _____ Date read _____ Negative _____ Positive _____

Print Licensed Medical Provider Name or stamp

Address

Phone

Licensed Medical Provider or Clinic Signature _____ Today's date: _____

Date of last
physical exam: _____