St. Patrick of Heatherdowns
4201 Heatherdowns Blvd.
Toledo, Ohio 43614
(419) 381-1775

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 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/animal/drug _____
4. Childhood Diseases: (i.e. chicken pox) _____
5. Medication: (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 Information

Dentist _____

Address _____

Phone _____

St. Patrick of Heatherdowns 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, 1 Varicella
(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 made 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 _____ _____