Most Blessed Sacrament School

Most Blessed Sacrament Parish School
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OHIO SCHOOL HEALTH HISTORY

To be completed by parent or guardian

FOR OFFICE USE:
School_____ Enrolled_____ Withdrawn_____

Child's Full Name: Last First Middle

Sex: ☐Male ☐Female

Birthdate: Month Day Year

Child's Address:

Father's Name:

Father's Address:

Father's Phones: Home/Primary Phone Cell Phone Work Phone

Mother's Name:

Mother's Address:

Mother's Phones: Home/Primary Phone Cell Phone Work Phone

With whom does child live? Name Address

Who is this child's legal Guardian?

FAMILY HISTORY: Pleas list this child's brothers and sisters.

NAME	BIRTH YEAR	SEX	NAME	BIRTH YEAR	SEX

PERINATAL HISTORY:

Did the mother have any unusual physical or emotional illness during this pregnancy? ☐ Yes ☐ No If Yes, explain briefly:

How old was the mother when this child was born?

Was this infant born: ☐ Full Term ☐ Early ☐ Late

What was this infant's birth weight?

Did the infant have any sickness or problems while in the nursery? ☐ Yes ☐ No If Yes, explain briefly:

DEVELOPMENTAL HISTORY:

Please give the approximate age at which this child:

Walked alone _____ Spoke in sentences_____

Was Toilet trained_____ Dressed self

How does this child's development compare to other children, such as his/her brothers/sisters or playmates?

☐ About the same ☐ Slower ☐ Faster

CHILD HEALTH HISTORY (continued)

Tuberculin test (latest): ☐ Negative ☐ Positive Date:_____	Initial immunization information by: _____ Date:_____

I. HEALTH CONDITIONS: Please check any that this child has had

	Abnormal spinal curvature (scoliosis ,etc.)		Concern about relation w/siblings/ friends		Frequent sore throat infections		Pregnancy
	Allergies or hay fever		Cystic Fibrosis		Heart disease, type_____		Rheumatic fever
	Anemia		Diabetes		Hepatitis		Seizures or epilepsy
	Asthma or wheezing		Eczema		Kidney disease, Type_____		Sickle cell disease
	Bedwetting at night		Emotional		Measles ("old-fashioned" or "ten day"		Stool soiling
	Behavior problem		Ear problem, poor hearing		Meningitis or encephalitis		Substance abuse (alcohol, drugs)
	Birth or congenital malformation		Eye problem, poor vision		Mumps		Suicide attempt
	Cancer type_____		Frequent headaches		Near-drowning or near-suffocation		Toothaches or dental infections
	Chicken Pox		Frequent skin infections		Nervous twitches or tics		Urinary Tract infection
	Chronic diarrhea or constipation				Poisoning		Wetting during day

II. ALLERGIES : Please list and describe allergies or reactions to:

Medicine/drugs
Foods/plants/animals/other
Recommended treatment if allergy is severe

III. INJURIES AND ILLNESSES

Injuries/Illness	Age of child	Hospitalized?

Does child always wear seat belts in cars? ☐ Yes ☐ No

IV. ADDITIONAL INFORMATION

What mediations are given daily?
What medications are given frequently, but not daily?

This child is usually: ☐Very Active ☐ Normally Active ☐Rather Inactive

Do you have any concern about how your child gets along with other children?
Do you have other comments or concerns about this child's health, development, behavior, family or home life that you would like the school to be aware of? If yes, explain briefly.

Completed by:

Please print:_____ Signature:_____