ST. JOAN OF ARC SCHOOL **DIOCESE OF TRENTON** **HEALTH RECORD**

PLEASE PRINT CLEARLY

Name____ Sex________ Date of Birth___________________

Address____ Tel. #____________ Emergency #_____________

Dr.'s Name_______________________________ Dr.'s Address_____________________________________

Dr.'s Telephone #__________________________ Student is Entering Grade___________________________

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IMMUNIZATION RECORD - DOCTOR CERTIFICATE AND DATES REQUIRED

PLEASE NOTE: All immunizations are required by the New Jersey Board of Health and must be administered before a child may be admitted to FIRST GRADE.

VACCINE TYPE	Disease Mo/Yr	1st Dose Mo/Day/Yr	2nd Dose Mo/Day/Yr	3rd Dose Mo/Day/Yr	4th Dose Mo/Day/Yr	5th Dose Mo/Day/Yr	6th Dose Mo/Day/Yr
Diphtheria & Tetanus (DPT and/or Td)							
Oral Polio Vaccine (OPV)							
MMR							
Measles							
Rubella							
Mumps							
Varicella							
Hib Vaccine							
Hepatitis B							
Prevnar							
TB tests (Type & Date)							

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FAMILY MEDICAL HISTORY

Has anyone in the family ever had:

	Yes	No	Indicate relationship (Mother, Father, Sibling only)
Diabetes	___	___	____
Tuberculosis	___	___	____
Heart disease	___	___	____
High blood pressure	___	___	____
Stroke	___	___	____
Kidney disease	___	___	____
Cancer	___	___	____
Mental Illness	___	___	____
Convulsive disorder	___	___	____
Asthma	___	___	____
Genetic diseases	___	___	____

Are there any conditions in the family which might affect your child adversely?

If so, please explain:____

Parent Signature:____