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

*PLEASE PRINT CLEARLY*

Name_____ Sex Female Date of Birth_____

Address_____ Tel. #_____Emerg. #_____

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 **(Attach Copy)** before a child may be admitted to Kindergarten.

Does your child have any medical history of the following:

| | Yes | No | | Yes | No |
|---|---|---|---|---|---|
| Allergies to Food or Bites | ☐ | ☐ | Frequent headaches | ☐ | ☐ |
| Appendectomy | ☐ | ☐ | Frequent sore throats | ☐ | ☐ |
| Asthma | ☐ | ☐ | Frequent urinary infections | ☐ | ☐ |
| Broken bones | ☐ | ☐ | Gluten Allergy | ☐ | ☐ |
| Chicken Pox | ☐ | ☐ | Heart Disorder | ☐ | ☐ |
| Cuts needing a doctor | ☐ | ☐ | Hepatitis | ☐ | ☐ |
| Diabetes | ☐ | ☐ | Hernia Repair | ☐ | ☐ |
| Drug Sensitivity | ☐ | ☐ | Kidney Disorder | ☐ | ☐ |
| Elevated blood pressure | ☐ | ☐ | Other | ☐ | ☐ |
| Elevated cholesterol | ☐ | ☐ | Persistent mouth breathing | ☐ | ☐ |
| Fainting | ☐ | ☐ | Poisoning | ☐ | ☐ |
| Frequent colds | ☐ | ☐ | Seasonal Allergies | ☐ | ☐ |
| Frequent digestive disturbance | ☐ | ☐ | Seizure Disorder | ☐ | ☐ |
| Frequent pain: Joints | ☐ | ☐ | Strep Throat | ☐ | ☐ |
| Muscular | ☐ | ☐ | Tonsillectomy/Adenoidectomy | ☐ | ☐ |
| Other | ☐ | ☐ | | | |

If yes to any of the above, please give details:_____

_____

_____

Has the child ever had vision examined professionally? Yes ☐ No ☐

Did the child ever have an eye injury? Yes ☐ No ☐

Has the child ever had vision questioned in preschool screening? Yes ☐ No ☐

Has the child ever had hearing examined professionally? Yes ☐ No ☐

Did the child have frequent ear infections during first five years? Yes ☐ No ☐

If so, how was it treated? Tubes in ears ☐ Medication ☐ Both ☐

Is your child presently taking medication? If so specify reason and kind.

_____

Is your child under medical treatment at present? If so specify.

_____

Please indicate any physical condition you feel the school should be aware of.

_____

Parent Signature:_____ Date:_____