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:_____