# *St. Joseph School*

5411 South Main Street
Sylvania, OH 43560
419 882-6670

**Kindergarten Health History Form**

Child's name_____ Male/Female Birthdate____
(circle one)
Mother's Name_____ Father's Name_____

With whom does the child live?_____
Who is the child's legal guardian?_____

Perinatal/Developmental History

Infant born: Full Term or Premature(circle one) Birth weight: _____
Any illness or problems while in the Nursery?_____
Approximate age at which this child:
Walked alone_____ Toilet Trained_____ Spoke in Sentences_____
Dressed self _____ How does this child's development compare to
Brothers/sisters or playmates? About the same slower faster (circle one)

Medical History

1. Health Conditions: _____
_____

2. History of Hospitalization: _____
_____

3. Allergies:(food, plant, animal, drug)_____
_____

4. Childhood Diseases: (i.e. chicken pox) _____
_____

5. Medication: (taken on a regular basis) _____
_____

6. Does this child receive special services (i.e. speech, physical therapy)? If so, please explain_____

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 to child) _____ Date_____

# *St. Joseph School*

5411 South Main Street
Sylvania, OH 43560
419 882-6670

**Dentist's Report for Kindergarten**

Child's Name_____ Age_____(years) _____ mos.

Dentist Name_____
Address _____
_____
Phone _____

Date of last exam_____

Findings_____
_____
_____

Signature of Dentist_____ Date_____

# *St. Joseph School*

5411 South Main Street
Sylvania, OH 43560
419 882-6670

**Physician's Report for Kindergarten**

Child's Name_____ Age _____(years) _____(mos.)

**Immunization Requirements: at least 5 DPT, 4 polio, 2 MMR, 3 or 4 Hep. B, 2 Varicella, and 4 HIB ( The fourth dose of polio administered on or after the fourth birthday)**

DPT 1._____ 2._____ 3._____ 4._____ 5._____

Polio 1._____ 2._____ 3._____ 4._____

MMR 1._____ 2._____

HIB 1._____ 2._____ 3._____ 4._____

Hep B 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_____
Impedence R_____ L_____
Frequent Ear Infections? _____
Does child have tubes? _____
Right_____ (date placed)
Left _____ (date placed)

Allergies:(food, plant, animal, drug)_____
_____

Physical Exam:

Essential 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)

**Physician Signature** _____ Physician name _____
Date of exam _____ Address_____
Phone _____ _____