St. Joseph Catholic School

Health History
To be completed by parent/guardian of children in Kindergarten and all new students.
Please complete one form per child.

Child's Name:______________________________________Grade:_______Birthdate:_______________

1. Does this child seem WELL most of the time? Yes_____No_____

2. In a year, has this child had as many as 3 episodes of EAR TROUBLE? Yes_____No_____
   Any HEARING concerns? Yes_____No_____

3. In a year, does this child usually have more than 2 COLDS or SORE THROAT infections with a fever? Yes_____No_____

4. Does this child complain frequently of headache, leg pains, stomach ache, or other PAIN? Type:_____________________ Yes_____No_____

5. Has this child had trouble with his/her EYES or VISION? Yes_____No_____
   Have they seen an eye DOCTOR? Yes_____No_____
   Were GLASSES prescribed? Yes_____No_____

6. Is this child's APPETITE usually good? Yes_____No_____

7. Are you concerned about this child's HEIGHT or WEIGHT? Yes_____No_____
   weight gain?_______ weight loss?________

8. Does this child CHEW unusual things such as pencils, window ledges, paint chips, plaster, or hair? Yes_____No_____

9. Does this child have difficulty sleeping? Yes_____No_____

10. Has this child been seen by a DENTIST in the last 6 months? Yes_____No_____
    If yes, when?______________
    Was all the recommended work completed? Yes_____No____

11. Has this child had a WELL CHILD check-up or SPORTS PHYSICAL in the last year? If yes, when?_____________ Yes_____No_____

12. Has this child been seen by a DOCTOR in the last year? Yes_____No_____
    For an Illness If yes, when?______________________________
    What type?____

    For an Injury If yes, when?_____________________________
    What type?____

13. Is this child taking any MEDICATIONS (prescription or over-the-counter) for any condition? (Asthma or Allergy meds or Inhalers, Diabetic meds or Insulin, Seizure meds, ADD/ADHD meds, Aspirin, Pain relievers, Vitamins, Laxatives or Stool softners etc.) Yes_____No_____
    If yes, what medications? _______________________________
    ____
    For what reason?____

Do you know the School Policy for giving and taking medications at school?

Yes_____No_____

OVER PLEASE

14. PAST MEDICAL HISTORY- Please check any of the following that this child has ever had. Please include dates (mo/year) when had or was diagnosed with where appropriate.

_____"Red" or "hard" measles
_____German or 3-day measles
_____Mumps
_____Chicken Pox (mo/year)_________
_____Meningitis
_____Hepatitis
_____Heart Trouble
_____High Blood Pressure
_____Scarlet Fever
_____Rheumatic Fever
_____Head Injury
_____High Fever (above 104 for 3 days)
_____Urinary/Kidney/Bladder Infections
_____Pneumonia
_____Birth Injury/defect______________
_____Premature birth
_____Trouble breathing at birth
_____Eczema
_____Asthma
_____Hayfever
_____Wheezing
_____Allergies:
Meds________________________
_____Allergies:
Food________________________
_____Convulsions/seizures
_____Arthritis
_____Diabetes
_____Cancer________________________

15. Has this child had any other ILLNESS or DISEASE not noted above? Yes_____No_____
What?__________________________When?________________

16. RECENT MEDICAL HISTORY - Please check any of the following that this child has had recently (within the past 4-6 weeks):

_____Difficulty or pain with urination
_____Diarrhea or Constipation
_____Tires easily
_____Swollen Glands
_____Bleeds/Bruises easily
_____Chronic cough
_____Dizziness/fainting spells
_____Shortness of breath
_____Joint pain

17. Has this child ever been HOSPITALIZED? Yes_____No_____
When?__________________________Why?________________

18. Does this child have any HANDICAPS or PHYSICAL RESTRICTIONS? Yes_____No_____
If yes, please list____

19. Has this child ever seen a SPECIALIST? Yes_____No_____
If yes, when and for what?__________________________________

20. Do you have any BEHAVIORAL concerns about this child? Yes_____No_____
____
____

21. Is there anything else you would like to tell us about your child related to their health needs? Yes_____No_____
____
____
____

Form completed by____ Date_________________

This information is important in providing a safe learning environment for your child. Please notify Health Services of any changes throughout the year.

Thank you.

Dahri Nelson, RN
Health Office
St. Joseph Catholic School
952-442-4500

Sara Eischens, RN, LSN
District 110 Health Coordinator
Waconia High Schooll
952-442-0670