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

PLEASE PRINT CLEARLY

Name____ Sex__________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:____

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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.

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

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

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Parent Signature:____ Date:_________