

Saint Thomas Academy

Student's Health History

To be completed before pupil is examined by physician

Please complete both sides.

The information contained in this form is confidential.

Name: _____ Birthday: _____

Address: _____ Telephone: _____

Father or Guardian: _____ Mother or Guardian: _____

Physician: _____

Health History: Major illness, Operations, Injuries or Problems _____

Personal and Family History:

- Has the student ever had rheumatic fever or a heart murmur? _____
- Has the student ever had a nervous breakdown, convulsions, or mental disease? _____
- Has any member of his family ever had tuberculosis, diabetes, asthma, mental, or nervous disorder? _____
- Can the student take full course in physical training, calisthenics, and swimming? _____
- Has he your permission to participate in intercollegiate or intramural athletics such as football, basketball and baseball? _____

Immunizations

Enter the Month, Day and Year for all vaccines the pupil received. (Do NOT use (√) or (X)).

Type of Vaccine	1 st dose	2 nd dose	3 rd dose	4 th dose	5 th dose
Diphtheria, Tetanus, and Pertussis (DtaP, DTP)					
Diphtheria and Tetanus (DT) – pediatric formulation (<7 yrs)					
Tetanus and Diphtheria (Td) – adult formulation (>7 yrs)					
Polio (IPV, OPV)					
Measles, Mumps, & Rubella (MMR) (minimum age: 12 mos.)					
Hepatitis B (HBV)*					
Varicella (Chickenpox)**					
Pneumococcal Conjugate (PCV)***					
Haemophilus influenzae type b (Hib)***					

*Hepatitis B is required for kindergarten and 7th grade.

**Varicella vaccine will be required starting fall 2004.

***PCV and Hib vaccine are recommended only for children through age 4 years.

Note for all school personnel: Be sure to initial and date any new information that you add to this form after the parent/guardian submits it. Also, record combination vaccines (e.g., DTP+Hib, Hib+HBV) in each applicable space.

Other: _____

Tuberculin Test Date: _____ Negative _____ Positive _____

Type: _____

Health Examination
To be completed by physician

Please complete **both** sides.

Name _____ Grade _____

Height _____ Weight _____ Scoliosis _____

Hemoglobin _____ Urine _____ Blood Pressure _____

Eyes

Glasses worn Yes _____ No _____
Vision R 20/ _____ L 20/ _____
Development Normal Yes _____ No _____

Ears

Hearing Aid Worn Yes _____ No _____
Hearing R _____ L _____
Speech Normal Yes _____ No _____

List any significant findings of the complete medical examination: _____

Recommendations Regarding Treatment and correction of Deficits: _____

Any Condition Which May Result in an Emergency? Yes _____ No _____

If Yes, Specify: _____

What Learning Problems, if any, Should be Watched for: _____

What Emotional Problems, if any, Should be Watched for: _____

Is There a Condition Which May Limit Participation in:

- | | | |
|------------------------|-----------|----------|
| A. Classroom Activity? | Yes _____ | No _____ |
| B. Physical Education? | Yes _____ | No _____ |
| C. competitive Sports? | Yes _____ | No _____ |

If Yes, Specify: _____

Is this student adequately immunized? Yes _____ No _____ (See reverse side)

If not, please advise parent to bring the student's immunizations up to date at this time and to have them recorded on this form.

Comments and Recommendations: _____

Date _____ Signature _____ M.D.

Address _____ Phone _____