ST. PIUS X SCHOOL
STUDENT HEALTH HISTORY

Students Name **Last** **First** **MI**	**Male** ☐ **Female** ☐	**Date of Birth (M/D/Y)** / /
Parents/Guardian:	**Grade:**	

Student Health Conditions:

☐ **NO medical conditions**
☐ **YES, my child receives regular medical/health care for the following conditions**

☐ Allergies	☐ Diabetes	☐ Seizure Disorder
☐ Asthma	☐ Depression	☐ Sickle Cell Anemia
☐ ADD/ADHD	☐ Ear problem/Hearing Difficulty	☐ Skin Conditions
☐ Autism	☐ Emotional Concerns	☐ Speech problems
☐ Behavior Concerns	☐ Headaches	☐ Traumatic brain injury
☐ Birth/congenital malformations	☐ Heart problems	☐ Vision problems/glasses/contacts
☐ Bone/muscle/joint problems	☐ Hemophilia	☐ Other _____
☐ Blood problems	☐ Juvenile arthritis	☐ Other _____
☐ Bowel/bladder problems	☐ Lead poisoning	☐ Other _____
☐ Cancer	☐ Migraines	☐ Other _____
☐ Cystic fibrosis	☐ Neuromuscular disorder	☐ Other _____

Please explain any conditions above or any reasons for hospitalizations:

Please indicate any allergies your child may have ☐ NKA (No Known Allergies)

Allergy Type	Allergen	Reaction	Recommended Actions
☐ Bee/Insect			
☐ Food			
☐ Medication			
☐ Other			

(*SEPARATE ALLERGY ACTION PLAN TO BE COMPLETED IF MEDICAL INTERVENTION NEEDED.)

Please list any prescription and over the counter medication that your child takes on a regular basis

Medication and dose	**Time**	**Reason**

Do any health and/or medical conditions require school restrictions, modifications, and/or intervention?
☐ YES ☐ NO If YES, please explain.

Does the student require any special procedures and/or treatments for their health condition(s)?
☐ YES ☐ NO If YES, please explain.

Please indicate any other information about your child's health or development that you think would be helpful for the school to know.

Signature	**Relationship to Student**	**Date**

(OVER →)

ST. PIUS X SCHOOL
HEALTH HISTORY CONTINUED

STUDENT NAME:	**GRADE:**

PLEASE COMPLETE OR ATTACH IMMUNIZATION RECORD (M/D/Y)

DTP (4-5) __/__/__ __/__/__ __/__/__ __/__/__ __/__/__
(Diptheria/Tetanus/Pertussis)

Td/Tdap (*Required for 7th Grade) __/__/__

POLIO (4-5) __/__/__ __/__/__ __/__/__ __/__/__ __/__/__

MMR (Measles/Mumps/Rubella) (2) __/__/__ __/__/__

HEPATITIS B (3) __/__/__ __/__/__ __/__/__

VARICELLA (Chicken Pox) (2) __/__/__ __/__/__

***HIB** __/__/__ __/__/__ __/__/__ __/__/__ __/__/__

***TB** __/__/__

*** HEPATITIS A** __/__/__ __/__/__

OTHER __/__/__

(*) NOT REQUIRED FOR KINDERGARTEN ENTRY

****Please see attached State of Ohio Immunization Guidelines**