**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**