St. Brendan School
4242 Brendan Lane
North Olmsted, Oh 44070
440.777.8433 (p) / 440.779.7997 (f)

School Health Questionnaire
Kindergarten-Grade 8
20 _____-20 _____

School_____ Grade _____

Transfer from _____ City of School _____

Child's Name _____ Date of Birth _____
Month Day Year

Address _____ Home Telephone #_____

Father/Guardian's Name _____ Mother/Guardian's Name _____

Name of Physician _____ Physician Telephone # _____

How often does the physician see your child? _____

Name of Dentist _____ Dentist Telephone # _____

PAST HISTORY OF CHILD (*Give year if possible*)

Chickenpox	_____	Bee Sting Allergy	_____	Diphtheria	_____
Whooping Cough	_____	Rheumatic Fever	_____	Poliomyelitis	_____
Eczema, Hay Fever, Asthma	_____	Mumps	_____	Scarlet Fever	_____
Regular Measles	_____	German Measles	_____	Hives	_____

Frequent Colds, Sore Throats _____

Convulsions (Explain)
_____
_____

Hospitalizations, Injuries or Serious Illnesses. (Explain and give year or age)
_____
_____

Any ear infections? ☐ Yes ☐ No Which ear? ☐ Left ☐ Right Hearing difficulty? ☐ Yes ☐No

Any vision difficulty? ☐ Yes ☐ No Wear glasses? ☐ Yes ☐ No

Name of Eye Specialist _____ Date of last examination_____

Any speech difficulty?
_____

Does your child eat breakfast?

_____

Are there any eating problems? (Explain)

_____

_____

What time does your child go to bed? _____ Get up? _____

Is elimination satisfactory? _____ Is control satisfactory? _____ Bowels _____ Bladder _____

FAMILY HISTORY

(*Indicate any member of the immediate family who has or has had the following illnesses.)*

Tuberculosis _____ Diabetes _____ Rheumatic Fever _____

HEALTH PROTECTIVE MEASURES

Immunization Record. Enter month / day / year of each immunization.

DPT: 1 _____ 2 _____ 3 _____ 4 _____ *5 _____

POLIO: 1 _____ 2_____ 3 _____ 4 _____

MEASLES, MUMPS, RUBELLA (usually combined as MMR): 1 _____ *2 _____

If separate, measles _____, mumps _____, rubella _____

* Usually administered just prior to Preschool or school entrances.

_____Hepatitis B 1_____ 2 _____ 3 _____

_____ Hib 1 _____ 2 _____ 3 _____ 4 _____ 5 _____

_____ Varicella (Chicken Pox)

I hereby certify that my child has had the tuberculin test and immunizations as stated above.

_____ _____

Signature of Parent Date

Please complete and return to the School Office/Nurse by the first day of school.

Revised: 06.29.15