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 # ___________________________________

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

Name of Eye Specialist ______________________________________ Date of last examination________________________________

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

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 ____________

Over

MEDICAL HISTORY

Please check off the following conditions this student has been diagnosed with:

_____Allergies: Food_____________ Medication______________ Bee_____________ Seasonal_____________

_____Asthma: Inhaler? YES_____ NO______

Student will carry inhaler at school (Physician Authorization is needed)_____

Student will not carry inhaler at school_____

_____Diabetes: _____________________**(A Diabetes Care Plan is required)**

_____Seizures: ______________________**(A Seizure Care Plan is required)**

_____Heart Condition: ____________

_____Gastrointestinal: ____________

_____Migraines: _________________(A physician statement is recommended)

_____Scoliosis: __________________

_____Other: ____

Additional space to explain any conditions checked above: ____

Please explain any additional health problems, limitations or special medical concerns that the school should be aware of:

____

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

____

____

REQUIRED IMMUNIZATIONS

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 _________

Hepatitis B 1_______ 2 _______ 3 _______

Varicella (Chicken Pox) 1 _______ 2 _______

MCV4 (Meningococcal – Grade 7 & 8) 1 _______

* Usually administered just prior to Preschool or school entrances.

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.
A copy of your child's immunization can be attached to this form, or faxed to us from the doctor's office - 440-779-7997