



St. Patrick of Heatherdowns
4201 Heatherdowns Blvd.
Toledo, Ohio 43614
(419) 381-1775

Health History

Child's name _____ Birth date _____ Male ___ Female ___
Mother's name _____ Father's name _____ Phone # _____
With whom does the child live? _____ Legal Guardian(s)? Yes / No

Perinatal / Developmental History

Birth weight _____ Full term _____ Premature _____ Illness/problems in the nursery _____

Please give the approximate age your child:

Walked alone _____ Toilet trained _____ Dressed self _____ Spoke in sentences _____

How does development compare to siblings or playmates? Same _____ Slower _____ Faster _____

Medical History

1. Health Conditions: (i.e. asthma) _____
2. History of Hospitalization: _____
3. Allergies: (food/plant/animal/drug) _____
4. Childhood Diseases: (i.e. chicken pox) _____
5. Medication: (taken on a regular basis) _____

Do you have other comments about this child's health, development, behavior, family or home life that you feel the school should be aware of? If so, please explain briefly: _____

Completed by _____ (relationship) _____ Date _____

Dentist Report

Dentist _____ Date of last exam: _____

Address _____ Findings: _____

Phone _____

Signature of Dentist _____ Date _____

St. Patrick of Heatherdowns Health Record (Cont.)

Physician's Report

Child's Name: _____ Age _____ (years) _____ (mos.)

Immunizations: (Pre-School/Pre-K) 4 DPT, 3 Polio, 1 MMR, 3 Hepatitis B, & 4 HIB
(Kindergarten) 5 DPT, 4 Polio, 2 MMR, 3 Hepatitis B, 2 Varicella

DPT 1 _____ 2 _____ 3 _____ 4 _____ 5 _____
(4 sufficient if 4th dose is given after 4th birthday)

Polio 1 _____ 2 _____ 3 _____ 4 _____ 5 _____

MMR 1 _____ 2 _____

Hep B 1 _____ 2 _____ 3 _____

HIB 1 _____ 2 _____ 3 _____ 4 _____

Varicella 1 _____ 2 _____

Other Type _____ date _____ Type _____ date _____

Screening Tests:

Vision (pass / fail):

Distance Acuity R _____ L _____

Muscle Balance R _____ L _____

Farsightedness R _____ L _____

Color (Circle) Pass / Fail

Wears glasses Yes / No

Referral made Yes / No

Hearing (pass / fail):

Pure Tone R _____ L _____

Impedance R _____ L _____

Frequent ear infections? _____

Does child have tubes? _____

Right _____ (date(s) placed)

Left _____ (date(s) placed)

Physical Exam:

Essentially normal: _____ Abnormalities as follows: _____

Is this child able to participate in all school activities? Yes _____ No _____

If no, please explain: _____

This is to certify that the above named student has been seen in our office and is in suitable condition to attend a preschool or kindergarten program.

(PRINT OR STAMP BELOW)

Signature _____

Physician name _____

Date of exam _____

Address _____

Phone _____
