Medical Alert/Allergies _____

HEALTH RECORD

Saint Barbara School
Massillon, Ohio

1. School _____ Grade ___ 3. School _____ Grade ___
2. School _____ Grade ___ 4. School _____ Grade ___

FAMILY INFORMATION:

Name _____ Date of Birth _____
(Last) (First) (Middle)

Home Address _____ Phone _____
(PENCIL)

Father _____ Phone _____
(PENCIL) (Name) (Place of Occupation)

Mother _____ Phone _____
(PENCIL) (Name) (Place of Occupation)

Step Parent/Guardian _____ Phone _____
(PENCIL) (Name) (Place of Occupation)

CARE OF CHILD IN CASE OF EMERGENCY AT SCHOOL:

Physician _____ Hospital Choice _____

Dentist _____ Glasses/Contacts _____ Doctor _____

In case parent cannot be located—person who may be called to transport student and accept responsibility.

Friend? Relative? _____ Phone _____

_____ Phone _____

Signature _____ Date _____
(Parent or Guardian)

HEALTH HISTORY (INK)

	Year		Year
Allergies/Hayfever		Hepatitis A,B,C, other	
Asthma		Nose Bleeds (frequent)	
Chicken Pox		Pneumonia	
Diabetes		Rheumatic Fever	
Ear Infections/Tubes		Ring Worm–Impetigo	
Epilepsy		Scarlet Fever	
Heart Disease		Strep Throat	

IMMUNIZATIONS (INK)

	Date	Date	Date	Date	Date
DPT/DTaP					
Td/DT					
Polio (OPV)					
MMR					
Hib					
Hepatitis B					
Varivax (Chkn Px)					
Other					

TUBERCULIN TESTS

Type	Date	Result	Type	Date	Result

HOSPITALIZATION, SURGERY OR FRACTURES? (INK)

Date	

MEDICATIONS/TREATMENTS

SPECIAL HEALTH PROBLEMS? RESTRICTED ACTIVITY? (PENCIL)

Date	
	Preschool: