ST. CHARLES CATHOLICSCHOOL - LIMA, OHIO
Student Health Record

This form must be completed and presented on the first day of school.

Last Name First Name Middle Name

Birthdate _____ Sex _____ Age _____

Parent/Guardian Name _____

Address _____

Phone No. _____

DENTAL EXAMINATION

Number of carious teeth _____ Number of fillings _____

Other _____

Dentist's Signature _____ Date of Examination _____

Address _____ Phone _____

HEALTH HISTORY

Allergies _____ Hospitalized _____
Convulsions _____ _____
Chicken Pox _____ Scarlet Fever _____
Disabilities _____ TB Contact _____
Frequent Colds _____ Tonsillitis _____
Pneumonia _____ Whooping Cough _____
Medications _____ Other _____

Immunizations - Must be completed by physician

DPT 1_____ 2_____ 3_____ 4_____ 5_____

Polio 1_____ 2_____ 3_____ 4_____

MMR 1_____ 2_____ Varivax _____
(Measles, Mumps and Rubella)

Hepatitis B Vaccine 1_____ 2_____ 3_____

HIB Vaccine (Preschool) _____

Comments _____

PHYSICAL EXAMINATION - Must be completed by the examing physician.

Please use the following code:

Satisfactory-O Corrected-OO Observation-X Attention Needed-XX

Height _____ Weight _____
General Appearance _____
Cleanliness _____
Posture _____
Orthopedic _____
Nervous Disease _____
Nutrition _____
Mouth Breathing _____
Defective Breathing _____
Heart Murmur _____
Temperature _____
Hearing Acuity _____
Developmental Disorders _____

Abdomen _____
Tonsils _____
Lungs _____
Cervical Glands _____
Skin _____
Eyes _____
Ears _____
Teeth _____
Genitals _____
Blood Pressure _____
Vision Acuity _____
Other _____
Speech & Language Disorder _____

Physician's Signature _____ Date _____

Address _____ Phone _____

REVISED 1-14-02