

ST. JOHN'S SCHOOL
1802 SKIPPACK PIKE CENTER SQUARE, PA. 19422
610-279-5514

HEALTH FORM 2008-2009

CHILD'S NAME _____ Birth _____
Address _____ Zip _____ Phone _____

Family Health Insurance, Name & Group No. _____

DIRECTIONS: Parents/guardian fill in and sign for the information at the TOP of this form. Child's physician must sign for the information at the BOTTOM of the form.*

_____ Check here if you wish to discuss confidential information with school director/teacher.
Birth history (weight, prematurity, any other problems at birth) _____

What illnesses has the child had? At what age?

Chicken pox _____	Scarlet fever _____	Diabetes _____
Mumps _____	Measles _____	Hepatitis _____
Vision (glasses) _____	Hearing (aid) _____	Fracture _____
Epilepsy _____	T.B. _____	Other _____
Seizures/spells _____	Heart disease _____	

Does child have frequent colds? Explain _____
Tonsillitis? _____ Earaches? _____
Stomachaches? _____ Does child vomit easily? _____

Has child had any serious accidents? Explain _____

Allergies to food, medicine, insect bites/stings, or other: _____

Has your child ever had his/her vision tested? _____ Hearing tested? _____
Does your child wear corrective shoes, lenses (glasses)? _____

PARENT'S SIGNATURE _____ Date _____

*******THE FOLLOWING TO BE FILLED OUT BY THE CHILD'S PHYSICIAN*******

When has this child received the immunizations listed below? (Zerox copy may be attached).

DTP 1, 2, 3, _____	Hep B 1, 2, 3 _____
OPV/IPV 1, 2, 3 _____	TB _____
MMR _____	Chickenpox _____
Hib 1, 2, 3, 4 _____	Other _____

Date of most recent examination _____

PLEASE NOTE ANY RESTRICTIONS OR UNUSUAL HEALTH CONDITIONS THAT THIS CHILD MAY DISPLAY (EMOTIONAL PROBLEMS, PHYSICAL-MOTOR DIFFICULTIES, ETC.). YOUR FRANKNESS ABOUT ANY PHYSICAL RESTRICTION/DISABILITY WILL HELP OUR STAFF ENSURE OPTIMUM PROTECTION OF THE CHILD'S SAFETY.

Speech development Normal development _____ Delayed development _____

In your opinion, is this child physically and emotionally able to participate in our preschool program? Yes _____ Marginally (with help) _____

Physician _____ Phone _____

Address _____ Date _____