

MATER DEI ACADEMY
HEALTH HISTORY

Child's Name _____
Last First

Birthdate _____

Address _____

Home Phone(____) _____

Ohio School Immunization Law states that at the beginning of each school year or whenever a pupil enrolls in a school, he/she has **14 (fourteen) days** to provide written evidence that he/she meets or exceeds the minimum immunization standards. Including: DTap, Polio, MMR, Varicella, HIB, Hepatitis B, Tdap, and meningococcal according to the Ohio Department of Health Immunization schedule for the current school year.

IF THE STUDENTS INFORMATION IS NOT PROVIDED WITHIN THE PRESCRIBED TIME, HE/SHE MAY BE EXCLUDED FROM SCHOOL UNTIL HE/SHE DOES SO.

**** Please attach a copy of your child's vaccine record upon returning this form ****

MEDICAL HISTORY

Please indicate which family member has or has had the following illness or conditions:

- 1 Stroke, heart disease or hypertension under the age of 45 _____
- 2 Diabetes _____
- 3 Deafness _____
- 4. Allergies _____
- 5. Asthma _____

Has your child had any of the following diseases? Give year if possible.

Chicken Pox _____	Mumps _____	Scarlet Fever _____
Stomach Aches _____	Sore Throats _____	Epilepsy _____
Frequent Colds _____	Allergies _____	Diabetes _____
Hyperactivity _____	Ear Infections _____	Hay Fever _____
Nose Bleed _____	Frequent Fevers _____	Asthma _____
Eczema or Hives _____	Caps on Tooth or Spacers _____	
Wears Glasses _____	Date of Last Eye Exam _____	
Hearing Loss _____	Speech Impediment _____	
Broken Bones _____		

Hospitalization _____ Reason: _____

Development delays due to Birth Weight _____ Early Delivery _____

Any other information regarding child's general health _____

Parent Signature _____

Date _____