



St. Vincent - St. Mary High School
 15 North Maple Street • Akron, Ohio 44303 • (330) 253-9113



NEW STUDENT HEALTH RECORD

Student Name: _____ Year of Graduation: _____

Student Social Security Number: _____ - _____ - _____ Date of Birth: ____ / ____ / ____

Address: _____

City: _____ Zip _____ Phone _____

Student lives with: ___ Father ___ Mother ___ Stepfather ___ Stepmother ___ Guardian ___ Other - specify _____

Residential Parent or Guardian:

Mother _____ Daytime Phone _____

Mother's Home Address (if different from student): _____

Father _____ Daytime Phone _____

Father's Home Address (if different from student): _____

Other _____ Daytime Phone _____

Other Address: _____

Emergency Contact to be called if parent/guardian cannot be reached:

Name _____ Relationship _____

Address _____ City/State / Zip _____

Daytime Phone _____

According to Ohio Law, Sections 3313.671 and 370.13, a physician's copy of your child's immunization record must be on file in the school. Your child will not be permitted to attend school without this information on file. Please do not rely on records being sent from previous schools. Parents/Guardians are responsible for providing these records which **MUST BE ON FILE PRIOR TO THE FIRST DAY OF SCHOOL.**

Immunizations: Required by law to attend school

DTaP/DTP/DT	5th dose required if 4th dose given before age 4
Tetanus	Td or Tdap before Grade 7 (Adult dose recommended)
Polio	4th dose required if 3rd dose given before age 4
MMR	2nd dose required at or before Grade 7
Hepatitis B	3 doses required
Varicella (chickenpox)	2 doses required or date of disease
HIB	Pre-K only; 3 or 4 doses 0-14 mo., 1 dose if 15 mos. or older

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Health Conditions: Please check any that apply.

- | | | |
|---|---|--|
| <input type="checkbox"/> Allergies | <input type="checkbox"/> Cancer | <input type="checkbox"/> Frequent sore throat |
| <input type="checkbox"/> Anaphylactic reaction | <input type="checkbox"/> Cerebral Palsy | <input type="checkbox"/> Heart disease |
| <input type="checkbox"/> Asthma or wheezing | <input type="checkbox"/> Chickenpox - _____ (date) | <input type="checkbox"/> Hepatitis |
| <input type="checkbox"/> ADD/ADHD | <input type="checkbox"/> Cystic Fibrosis | <input type="checkbox"/> Juvenile Arthritis |
| <input type="checkbox"/> Behavior/Emotional concerns | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Meningitis/ Encephalitis |
| <input type="checkbox"/> Birth/Congenital malformations | <input type="checkbox"/> Ear problems/ Poor hearing | <input type="checkbox"/> Seizures/ Epilepsy |
| <input type="checkbox"/> Blood problems | <input type="checkbox"/> Eczema/ Skin conditions | <input type="checkbox"/> Speech difficulties |
| <input type="checkbox"/> Bone/Joint problems | <input type="checkbox"/> Eye problems/ Poor vision | <input type="checkbox"/> Toothaches/ Dental problems |
| <input type="checkbox"/> Crohn's/ Ulcerative Colitis/ IBS | <input type="checkbox"/> Frequent headaches | <input type="checkbox"/> Urinary tract infections |

If you checked any of the conditions above, *please explain:* _____

Any other illnesses, injuries, surgeries, or hospitalizations: *Please explain:* _____

Allergies: Allergic to _____ Reactions/ Recommended Treatment _____

Medications: *Describe medicine your child takes regularly*

Medicine: _____ Reason: _____ How Often? _____

If your child must take medication at school, please request Medication Authorization Forms to be completed by your and your child's physician. These forms are also available on our website under the *FORMS* tab.