Saint Raphael School
525 Dover Center Road
Bay Village, OH 44140
440-871-6760

ST. RAPHAEL SCHOOL HEALTH QUESTIONNAIRE

School Transferred From			Grade
Child's Name	Gender	Age	Birthdate
Parent/Guardian 1	Parent/Guardian 2		

MEDICAL HISTORY

Has your child had any of the following?

_____Chickenpox	_____Rheumatic Fever	_____Asthma
_____Frequent Colds	_____Measles	_____Ear Infections
_____Scarlet Fever	_____Hay Fever/Allergies	_____Hearing Difficulty
_____Mumps	_____Diabetes	_____Speech Difficulty
_____Frequent Sore Throats	_____Allergy	_____Visual Difficulty

Name of Eye Specialist: _____ Date of Last Exam: _____

Hospitalizations (Reasons and Dates):_____

_____

Medication Being Taken (Reason, Name, Dosage):_____

_____

Other Health Problems: _____

Indicate if any member of the family has or had had the following:

_____Tuberculosis _____Diabetes _____Rheumatic Fever

IMMUNIZATIONS

TYPE	DATE (MO/DAY/YEAR)				
DTAP, DPT or DT					
Hep A					
Hep B					
HIB					
MMR					
POLIO					
VARICELLA					
OTHER					
OTHER					

Please give FULL dates for all immunizations. As your child receives future immunizations throughout their school years, please inform the school nurse of the type and date.
I hereby certify that this child has had the immunizations as stated above.

Parent Signature:	Date: