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**

revised 1/31/15

HEALTH RECORD - PAGE 2

Health Conditions: Please check any that apply.

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

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

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

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Allergies: Allergic to Reactions/ Recommended Treatment

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Medications: *Describe medicine your child takes regularly*

Medicine: Reason: How Often?

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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.