

HEALTH ENTRANCE REQUIREMENT TO ST. JOSEPH SCHOOL

Dear Parent or Guardian:

St. Joseph School Education Commission requires that students entering St. Joseph School have a current health record including: a health history, a medical examination and adequate immunization. The following information is requested so that the school and parent can work together to meet the physical, intellectual and emotional needs of the child. Please fill out the information requested in Section I. The remaining sections are to be completed by a doctor or nurse.

Section I – Personal

Child's Name _____ Sex _____ Date of Birth ____ / ____ / ____
(Last) (First) (Middle)

Address _____ Today's Date ____ / ____ / ____
(Number & Street) (City) (Zip)

Parent or Guardian's Name _____ Home Phone _____ Work Phone _____

With Whom Does Child Live? _____ School _____ Grade _____

ALLERGIES	Mild	Moderate	Severe		Mild	Moderate	Severe
Animals (kind)	_____	_____	_____	Food (Kind)	_____	_____	_____
Asthma	_____	_____	_____	Hayfever	_____	_____	_____
Drug (type)	_____	_____	_____	Bee Stings	_____	_____	_____
PLEASE EXPLAIN SPECIFIC REACTION FOR ANY CHECKED ABOVE _____							

DISEASES (Specify age)		
Measles (Red/Rubeola/10-Day)	_____	Mumps _____
Measles (German/Rubella/3-Day)	_____	Scarlet Fever _____
		Chickenpox _____
		Meningitis _____
Please explain if your child has any of the following problems:		
Convulsions	_____	Heart Disorder _____
Diabetes	_____	Dental _____
Epilepsy	_____	Orthopedic _____
Tonsillitis	_____	Vision/Eye _____
Emotional	_____	Hearing/Ear _____
Does your child take any medication regularly? (Please specify) _____		
Please explain any serious surgeries, illnesses, injuries or other physical problems (specify age): _____		

EMERGENCY CARE PERMISSION	
In case of illness or injury, you should contact one of the following persons:	
1. _____	Telephone _____ at _____
or 2. _____	Telephone _____ at _____
If it is impossible to contact one of the above persons, you may contact our family doctor _____	
Telephone _____ In case of serious illness or injury, I hereby request that authorized school personnel transfer my child directly to the hospital, or send by ambulance if needed, and I will assume all financial obligations.	
_____ (Signature of Parent)	

SECTION II – TESTS AND MEASUREMENTS

TESTS	Norm	Under Care	Ref.	TESTS	Norm	Under Care	Ref.
Vision tested ___ Yes ___ No Visual Acuity _____ Ocular Muscle _____ Other _____ Date _____				Urinalysis Done? ___ Yes ___ No			
Hearing tested? ___ Yes ___ No Audiometer _____ Other _____ Date _____				Blood Pressure? ___ Yes ___ No Reading: _____			
Hemoglobin/Hemotocrit Tested? ___ Yes ___ No				Height _____ Weight _____			

Essential Findings Deviating From Normal and/or Recommendations

Tuberculin Test (If given) Date: _____ Negative _____ Positive _____

SECTION III – IMMUNIZATION REQUIREMENTS

Michigan Law requires that all children enrolling in school must show adequate immunization for the following:

DPT/DT/Td	4 or more doses	INCLUDING A PRESCHOOL BOOSTER AFTER AGE 4 , followed by a Td booster every 10 years
Polio (OPV/PV)	3 or more doses	INCLUDING A PRESCHOOL BOOSTER AFTER AGE 4.
Measles Mumps Rubella	(MMR) 2 doses	First dose must be given on or after the first birthday. The second dose must be given at least thirty days from the first dose and at or after fifteen months of age or current laboratory evidence of immunity.
Hepatitis B		3 doses required for ages 4-18 years
Chickenpox (Varicella)		Recommended only (will be required in 2002) (1 dose through age 12) (2 doses over age 12).

State law prohibits a Michigan School district from admitting new entrants to school without current immunization record or a signed exemption. Waiver forms are available at the nurse's office for medical contraindication or religious objection. Failure to meet these requirements, as set by the Michigan Department of Public Health, requires the school district to **EXCLUDE** the child from attendance.

IMMUNIZATIONS (RECORD MONTH, DAY AND YEAR OF IMMUNIZATION)

DPT/DT						
Td	__/__/__	__/__/__	__/__/__	__/__/__	__/__/__	__/__/__
OPV/PV	__/__/__	__/__/__	__/__/__	__/__/__	__/__/__	
MMR	__/__/__	__/__/__				
Hepatitis B	__/__/__	__/__/__	__/__/__			
Chickenpox	__/__/__	__/__/__				

SECTION IV - RECOMMENDATIONS

It is my opinion that _____ is physically able to participate in all Health and Physical Education Classes and activities (or) **PLEASE STATE AND EXPLAIN ANY RESTRICTIONS IN ACTIVITY.**

Date _____

Examiner's Signature _____

Degree or License _____