

ST. LUKE CATHOLIC SCHOOL
1442 North Fairfield Road
Beavercreek, OH 45432
Phone: 426-8551 Fax: 426-6435

Student Health Screening Checklist

(For use with all preschoolers, kindergartners and new first graders.)

Parent/Guardian:

Please complete the form below in order to help the school staff to better understand your child. Place a check beside items which describe your child most of the time.



Child's Name _____ Date of Birth _____
First Middle Last Month/Day/Year

Name child is to be called _____

Father's Name _____ Mother's Name _____
First Last First Last

With whom does child live? _____

Address _____ Relationship _____
Name Home Phone

Who is this child's legal guardian? _____

Please list this child's brothers and sisters:

Name	Birth year	Sex	Name	Birth year	Sex
1. School			4. School		
2. School			5. School		
3. School			6. School		

DEVELOPMENTAL HISTORY

- Did the mother have any unusual physical or emotional illness during this pregnancy? yes _____ no _____
 If yes, explain briefly _____
- How old was the mother when this child was born? _____
- Was this infant born: full term _____ early _____ late _____ What was this infant's birth weight? _____
- Did the infant have any sickness or problems while in the nursery? yes _____ no _____
 If yes, explain briefly _____
- Please give the approximate age at which this child: walked alone _____ was toilet trained _____
 spoke in sentences _____ dressed self _____
- How does this child's development compare to other children, such as his or her brothers/ sisters or playmates?
 About the same _____ slower _____ faster _____

Please check applicable items listed below:

- | | |
|--|--|
| _____ Plays well with other children | _____ Has speech problems |
| _____ Prefers to play alone | _____ Tires easily |
| _____ Gets along well with adults | _____ Is not toilet trained |
| _____ Is shy | _____ Sucks thumb |
| _____ Shares willingly | _____ Talks easily and willingly |
| _____ Has temper tantrums | _____ Knows full name |
| _____ Has a good appetite | _____ Uses scissors |
| _____ Eats a variety of foods | _____ Has been read to |
| _____ Has some specific fears | _____ Reads some words |
| _____ (please explain if checked.) | _____ Reads with little or no assistance |
| _____ | _____ Usually uses right hand |
| _____ Will be walking to school | _____ Can follow simple directions |
| _____ Will ride regular school bus | _____ Can put together simple puzzles |
| _____ Will have other form of transportation | _____ Attended preschool |
| _____ Has a good attitude toward entering kindergarten | _____ Name of School _____ |
| _____ Dresses self | |

Length of time: _____

HEALTH CONDITIONS - Please check any that this child has had:

- Abnormal spinal curvature (scoliosis, etc.)
- Allergies or hayfever
- Anemia
- Arthritis
- Asthma or wheezing
- Bedwetting at night
- Behavior problem
- Birth or congenital malformation
- Cancer, type _____
- Chicken pox
- Chronic diarrhea or constipation
- Concern about relationship with siblings or friends
- Cystic fibrosis
- Diabetes
- Ear Problems
- Eczema
- Emotional problems
- Eye problems, poor vision
- Frequent headaches

- Frequent skin infections
- Frequent sore throat infections
- Heart disease, type _____
- Hepatitis
- Kidney disease, type _____
- Measles ("old fashioned" or "ten day")
- Meningitis or encephalitis
- Multiple ear infections (3 or more)
- Mumps
- Near-drowning or near-suffocation
- Nervous twitches or tics
- Poisoning
- Rheumatic fever
- Seizures or epilepsy
- Sickle cell disease
- Stool soiling
- Toothaches or dental infections
- Urinary tract infection
- Wetting during day

ALLERGIES Please list and describe allergies or reactions to:

Medicines/drugs _____
 Foods/plants/animals/other _____
 Recommended treatment if allergy is severe _____

INJURIES AND ILLNESSES - Please list any severe injuries or illnesses:

Injuries/Illnesses	Age of Child	If Hospitalized (check)
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Does this child always wear seatbelts in cars? Yes _____ No _____

ADDITIONAL INFORMATION:

What medications are given daily? _____
 What medications are given frequently, but not daily? _____
 This child is usually: very active _____ normally active _____ rather inactive _____
 Do you have any concern about how your child gets along with other children? _____

Completed by: _____

Relationship to Child: _____

Date: _____

Thank you for your cooperation.