

St. Theresa School  
40 St. Theresa Avenue  
West Roxbury, MA 02132  
617-323-1050

**ENTRANCE REQUIREMENTS**

- **COMPLETE IMMUNIZATIONS**
  
- **REPORT OF PHYSICAL EXAMINATION DONE** **After 09/01/10**
  
- **TB ASSESSMENT**
  
- **HEALTH HISTORY COMPLETED BY PARENT**  
(Done at registration before seeing the nurse)
  
- **REPORT OF A LEAD TEST FOR ALL STUDENTS ENTERING ECP, PK, KI or KII** (Child does not need a new lead test at this time. The report may be any lead test done after the age of nine months.)
  - **ALL REQUIREMENTS SHOULD BE COMPLETED BY THE FIRST DAY OF SCHOOL. CHILDREN WHO DO NOT MEET THE REQUIREMENTS WILL BE EXCLUDED FROM SCHOOL UNTIL THE REQUIREMENTS ARE MET.**

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INTERVAL HEALTH HISTORY – Grades ECP – 8

**PLEASE BE SURE TO COMPLETE BOTH PAGES OF THIS FORM**

Student's Name \_\_\_\_\_ Grade \_\_\_\_\_  
(Please print)

Please update the following health information for your child. Give dates, if possible.

Doctor/Health Center \_\_\_\_\_ Phone \_\_\_\_\_  
Health Insurance \_\_\_\_\_ Policy # \_\_\_\_\_  
Date of last Physical Exam \_\_\_\_\_  
Dentist \_\_\_\_\_  
Date of Last Dental Exam \_\_\_\_\_  
Legal Guardian: Both Parents \_\_\_ Mother \_\_\_ Father \_\_\_ Other \_\_\_  
Name of Legal Guardian \_\_\_\_\_

	Yes	No
Accidents		
Allergies		
Asthma		
Respiratory Infections		
Communicable Diseases		
Fractures		
Other Bone/Joint Problems		
Seizures		
Dental Problems		
Ear-Throat Infections		
Frequent Headaches		
Kidney Urinary Problems		
Heart Murmur		
Menstrual Problems		
Hospitalizations		
Operations		
Bowel Problems		
Vision/Hearing/Speech Problems		
Diabetes		

Any Recent Screenings?  
For Example:  
Vision/Hearing/Scoliosis  
\_\_\_\_\_  
Date(s) \_\_\_\_\_  
Type \_\_\_\_\_  
Results \_\_\_\_\_  
\_\_\_\_\_  
Date(s) \_\_\_\_\_  
Type \_\_\_\_\_

If Yes, please, explain

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

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Student's name \_\_\_\_\_ Grade \_\_\_\_\_

Does your child wear glasses? Yes \_\_\_\_\_ No \_\_\_\_\_

If child wears glasses, please specify when child is to wear glasses during school:

Full time \_\_\_\_\_ Reading \_\_\_\_\_ Distance \_\_\_\_\_ Other \_\_\_\_\_

Has your child had Chicken Pox Disease: Yes \_\_\_\_\_ Date \_\_\_\_\_ No \_\_\_\_\_

If your child has had chicken pox, a physician certified reliable history must be on file at the school. A note should be on file for all students, regardless of grade.

Does your child take any medication on daily basis? If yes, please specify.

\_\_\_\_\_

\_\_\_\_\_  
Parent/Guardian Signature

\_\_\_\_\_  
Date

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Dear Parent:

In order to keep your child's health record up to date and provide better health services, we ask that you complete both pages of this form, sign and return it to the school nurses as soon as possible.

*There may be times when it will be necessary to share some of this information with the School Principal, your child's teacher, or other members of the school faculty/staff. If there is any reason you would not want this information shared, please contact us.*

Please feel free to contact us if you have any questions regarding this form.

Thank you for your cooperation.

Lynn Perella, R.N.  
Donna Twohig, R.N.