Parent's pages 1-4

Ohio School Health History

Child's Name	Gender	Age	Birthdate
_____ ____ male ____ female			
Ethnicity ____ Caucasian ____ African American ____ Hispanic ____ Asian American ____ Other			
Who is the child's legal guardian?	Who does the child live with?	Child's address	
Parent/Guardian	Parent/Guardian Address	Home phone number	

Social Service History

"X" the line if you have contact with any of the following agencies:

____ Child Protective Services If yes, Case Worker's Name _____
____ Legal/Court System
____ Family Counseling Services
____ Mental Health Provider
____ Other: _____

"X" the line if you or your child receive any of the following medical assistance:

____ SSI, Disability ____ Healthy Start ____ Insurance
____ LEAP ____ Medicaid/CHIP ____ Other: _____

Family History

Please list first and last name of all the child's family members including parents and siblings.

Name	Birthdate	Gender	Health Concerns	Is the child in school?	If so, where?
1.					
2.					
3.					
4.					
5.					

Perinatal 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 the child was born? Was the infant born: What was the infants birth weight? ____ Full term ____ Early ____Late _____ lbs. _____ oz.
Did the infant have any sickness or problems? ____ yes ____ no

Developmental History

Please give the approximate age at which this child: Walked alone _____ Spoke in sentences _____ Toilet trained _____ Dressed self _____
How does this child's development compare to other children, such as his or her brothers/sisters or playmates? ____ About the same ____ Delayed ____ Advanced

Allergies

Please list and describe allergies or reactions.

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

Injuries, Illness & Hospitalizations

Please list any severe injuries, illnesses, and hospitalizations including inpatient and outpatient surgical procedures.

Injuries/Illness/Hospitalizations	**Age**	**If hospitalized, please explain.**

Does your child always wear a seatbelt while riding in automobiles

____ yes ____ no

Does the student wear a helmet when bicycling, skating/rollerblading or riding a motorcycle?

____ yes ____ no

Medication Information

Please describe any medications that your child takes daily and frequently.

Name of Medication	What is the medication taken for?	How often is the medication taken? What time is the medication administered?

Health Conditions

Please check any medical conditions that the child currently has or has had in the past.

____ Abnormal spinal curvature

____ Allergies/hayfever

____ Anemia

____ Anaphylactic reaction

____ Asthma or wheezing

____ Attention deficit disorder (ADD)

____ Behavior problem

____ Birth or congenital malformation

____ Cancer Type _____

____ Chickenpox When _____

____ Chronic diarrhea or constipation

____ Chronic ear infections

____ Concern about relation with siblings or friends

____ Cystic Fibrosis

____ Diabetes

____ Eczema/Chronic skin conditions

____ Emotional problems

____ Eye problems, poor vision

____ Frequent headaches

____ Frequent sore throats

____ Heart disease Type _____

____ Hemophilia

____ Hepatitis

____ HIV positive

____ Hyperactivity

____ Juvenile Arthritis

____ Kidney disease Type _____

____ Measles (10 day)

____ Meningitis or Encephalitis

____ Mumps

____ Mutism

____ Near-drowning/Near-suffocation

____ Nervous twitches or tics

____ Poisoning

____ Rheumatic fever

____ Seizure disorder/Epilepsy

____ Sickle Cell Disease

____ Speech difficulties

____ Stool soiling

____ Toothaches or dental problems

____ Tourette's Syndrome

____ Urinary tract infections

____ Wetting during the day or night

Behavioral History

The child is usually: ____ very active ____ Normally active ____ Rather inactive

Has your child ever been violent or acted out the following manner towards adults or children:

____ Hitting ____ Kicking ____ Biting ____ Fighting ____ Scratching

Do you have any concern about how your child gets along with other children?

____ yes ____ no If yes, explain _____

_____

_____

Please add any comments or concerns you have about your child's health, development, behavior, family or home life that you would like the school to be aware of. _____

_____

_____

_____

To enter school, the child must have 4 DPT (5 if 4th was given before age 4); 3 Polio (4 if 3rd dose was given before age 4); 2 MMR; Hepatitis B series of 3 and the Varicella (Chicken Pox) immunization. If the child has had Chicken Pox a note stating that is required.

Verification completed by: _____ Date: _____

To be taken to child's doctor for physical Physicians pages 5-6

Ohio School Health History

School _____
Enrolled _____

Child's Name	Gender	Age	Birthdate
	____ male ____ female		

Ethnicity ____ American Indian/Alaskan Native ____ White (Non-Hispanic) ____ Black (Non-Hispanic)
____ Hispanic ____ Asian/Pacific Islander ____ Multiracial

Objective Data

Height	Weight	B.P.

Immunizations Shaded boxes are required for school entry.					
Type	**Date M/D/Y**				
DTaP					5th dose required if 4th dose given before age 4
DT/Td					
POLIO				4th dose required if 3rd dose was given before age 4.	
MMR				2nd dose required for K 2nd dose required for gr. 7-12	
HEPATITIS B					
VARICELLA				If child has had the Chicken Pox, a note stating that will be required for his/her file.	
HIB (prior to age 5 only)				0-14 moths: 3-4 doses 15-59 months: 1 dose	
TUBERCULIN TEST					
ROTAVIRUS (given @ 2-4-6 mo, not after 12 months)					
OTHER					

Screening Tests

Vision Date	**Hearing Date**
Distance Acuity ____ Right ____ Left	Pure tone testing:
Muscle Balance _____ Pass _____ Fail _____ Not done	Right ear _____ Pass _____ Fail _____ Not done
Farsightedness _____ Pass _____ Fail _____ Not done	Left ear _____ Pass _____ Fail _____ Not done
Color _____ Pass _____ Fail _____ Not done	Child wears hearing aid ____ Yes ____ No
Child wears glasses ____ Yes ____ No	Testing with hearing aid? ____ Yes ____ No
Tested with glasses ____ Yes ____ No	Referral made? ____ Yes ____ No
Referral made? ____ Yes ____ No	
Specify Test/Equipment _____	Other test (specify) _____

Speech Assessment Date

____ Child has no dissemble speech problem

____ Child has possible problem with: ____ Articulation ____ Rhythm ____ Voice ____ Language

Speech evaluation is recommended: ____ Yes ____ No

Laboratory Tests

___ Hemoglobin/Hematocrit ____ Urine protein ____ Urine blood ____ Urine glucose
___ Other _____

Physical Examination

Date of examination: _____
____ This child is essentially within normal limits
____ This child is not within normal limits
Explain :

Does this child have any physical, developmental or behavioral problems? Suggest special programs, placement or attention that the school can provide.

Activities & Limitations

Can the child participate fully in the following activities:
Classroom and academic activities ____ yes ____ no
Physical education classes ____ yes ____ no
Competitive athletics ____ yes ____ no
Contact & collision sports ____ yes ____ no
Specify any limitations:

Is this child on any medications? ____ yes ____ no
Explain:

Examiner's Signature _____ Date signed _____

Examiner's Printed Name _____
Address _____
_____
Phone _____

Ohio School Health History

School _____
Enrolled _____

Oral Assessment

Child's Name	Gender	Age	Birthdate
	____ male ____ female		
Ethnicity			
____ Caucasian ____ African American ____ Hispanic ____ Asian American ____ Other			

The following services have been performed:

____ Examination by dentist ____ Orthodontic assessment ____ Oral screening
____ Dental sealants ____ Radiographs ____ Fluoride application
____ Oral prophylaxis (cleaning) ____ Diagnosis ____ Prescription for fluoride supplements

The following oral hygiene instruction was provided:

____ Toothbrushing ____ Diet counseling related to dental health
____ Flossing ____ Home/school use of fluoride mouthrinse

The following statements are applicable:

____ No apparent care needed at this time.
____ All necessary preventive services have been performed. (Fluoride treatment, prophylaxia)
____ No restorative services are required at this time.
____ Further treatment is indicated. (See comments)
____ Further appointments have been arranged. (ex. Orthodontic, restorative)

Comments:

Examiner's Signature _____ Date signed _____

Examiner's Printed Name _____
Address _____
_____
Phone _____