

OHIO SCHOOL HEALTH HISTORY

To be completed by parent or guardian

School _____
Enrolled _____
Withdrawn _____

Child's full name _____
LAST FIRST MIDDLE
male _____ female _____ birthdate _____ month _____ day _____ year _____

Child's address _____

Father's name _____

his address (if different from child's) _____

his work phone _____ his home phone _____

Mother's name _____

her address (if different from child's) _____

her work phone _____ her home phone _____

With whom does child live? _____ name _____ relationship _____

Who is this child's legal guardian? _____ name _____ relationship _____

Please list this child's brothers and sisters: _____

FAMILY HISTORY

	birth year	sex		birth year	sex
1.			6.		
2.			7.		
3.			8.		
4.			9.		
5.			10.		

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 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 _____

DEVELOPMENTAL HISTORY

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 _____

IMMUNIZATION RECORD

Type	DATE					
DTP	/ /	/ /	/ /	/ /	/ /	/ /
TD	/ /	/ /	/ /	/ /	/ /	/ /
Polio	/ /	/ /	/ /	/ /	/ /	/ /
Measles (Rubeola)	/ /	/ /	/ /	/ /	/ /	/ /
Rubella	/ /	/ /				
Mumps	/ /	/ /				
MMR Combined	/ /	/ /				
Other (Identify)	/ /	/ /				
	/ /	/ /	/ /	/ /	/ /	/ /

CHILD HEALTH HISTORY, CONTINUED:

Required compulsory immunization law: 4 DTP, 3 polio, (1 live measles vaccine, 1 rubella and 1 live mumps vaccine on or after child's first birthday).

Tuberculin Test (Latest)

Date _____

Negative _____

Positive _____

Initial immunization information provided by: _____

Date: _____

I. 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
- ☐ 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
- ☐ Poor hearing
- ☐ Pregnancy
- ☐ Rheumatic fever
- ☐ Seizures or epilepsy
- ☐ Sickle cell disease
- ☐ Stool soiling
- ☐ Substance abuse (alcohol, drugs)
- ☐ Suicide attempt
- ☐ Toothaches or dental infections
- ☐ Urinary tract infection
- ☐ Wetting during day

II. ALLERGIES - Please list and describe allergies or reactions to:

Medicines/drugs _____

Foods/plants/animals/other _____

Recommended treatment if allergy is severe _____

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

Injuries/Illnesses

Age of Child

If Hospitalized (check)

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

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

IV. 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? _____

Do you have other comments or concerns about this child's health, development, behavior, family or home life that you would like the school to be aware of? If yes, explain briefly _____

Completed by: _____

Relationship to child: _____