Ohio School Health History

To be completed by parent or guardian

School_____
Enrolled_____
Withdrawn_____

Child's full name Last	First	Middle	
Sex ☐ Male ☐ Female	Birthdate Month Day Year		
Child's address			
Father's name			
Father's address			
Father's home phone	Father's work phone	Father's cell phone	
Mother's name			
Mother's address			
Mother's home phone	Mother's work phone	Mother's cell phone	
With whom does child live?	Name	Address	

FAMILY HISTORY

Please list this child's brothers and sisters

Name	Birth Year	Sex	Name	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 _____ ☐ spoke in sentences _____ ☐ was 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 ☐ slower ☐ faster

IMMUNIZATION RECORD

Effective, Kindergarten 2006:
5-DPT, 4-Polio, 2-MMR, 3 Hepatitis B, 1 Varicella, 4-HIB

TYPE	DATE					
DTaP/DPT/DT or Td						
Polio						
MMR Combined						
Hepatitis B						
Varicella Vaccine						
HIB (prior to age 5 only)						
Tuberculin Skin Test						
Other (Identify)						

Child Health History, continued:

I. Health Conditions – Please check any that this child has had:

- ☐ Abnormal (spinal curvature, scoliosis, etc.)
- ☐ Allergies or Hay Fever
- ☐ Anemia
- ☐ Asthma or wheezing
- ☐ Bedwetting at night
- ☐ Behavior problem
- ☐ Birth or congenital malformation
- ☐ Cancer, type_____
- ☐ Chicken pox Date:_____
- ☐ Chronic diarrhea or constipation
- ☐ Concern about relation with siblings or friends
- ☐ Cystic fibrosis
- ☐ Diabetes
- ☐ Eczema
- ☐ Emotional
- ☐ Ear problems, poor hearing
- ☐ 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
- ☐ Mumps
- ☐ Near-drowning or near-suffocation
- ☐ Nervous twitches or tics
- ☐ Poisoning
- ☐ Pregnancy
- ☐ Rheumatic fever
- ☐ Seizures or epilepsy
- ☐ Sickle cell disease
- ☐ Stool soiling
- ☐ Substance abuse (alcohol, drugs)
- ☐ Suicide attempts
- ☐ 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 √

Does 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: **Date:**
Relationship to child: