

# Ohio Department of Health • School and Adolescent Health

## Health History

Student's name	Sex <input type="checkbox"/> Male <input type="checkbox"/> Female	Date of birth /      /
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**Family Health History** Please list allergies, heart problems, diabetes, cancer or other serious health conditions.

Father
Mother
Brothers and Sisters

**Birth and Developmental History**    No unusual birth or developmental history

Did the mother have any unusual physical or emotional illness during this pregnancy?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Was infant born full term? <input type="checkbox"/> Yes <input type="checkbox"/> No	Did the infant have any sickness or problems? <input type="checkbox"/> Yes <input type="checkbox"/> No
Briefly explain illness or problems.  	
How does the child's development compare to other children, such as his or her brothers/sisters or playmates? <input type="checkbox"/> About the same <input type="checkbox"/> Delayed <input type="checkbox"/> Advanced	

**Student Health Conditions**

<input type="checkbox"/> <b>YES</b> , my child receives regular medical/health care for the following conditions:		<input type="checkbox"/> <b>NO</b> medical conditions
<input type="checkbox"/> Allergies	<input type="checkbox"/> Diabetes	<input type="checkbox"/> Seizure disorder
<input type="checkbox"/> Asthma	<input type="checkbox"/> Depression	<input type="checkbox"/> Sickle cell anemia
<input type="checkbox"/> ADD/ADHD	<input type="checkbox"/> Ear problem/hearing difficulty	<input type="checkbox"/> Skin conditions
<input type="checkbox"/> Autism	<input type="checkbox"/> Emotional concerns	<input type="checkbox"/> Speech problems
<input type="checkbox"/> Behavior concerns	<input type="checkbox"/> Headaches	<input type="checkbox"/> Traumatic brain injury
<input type="checkbox"/> Birth/congenital malformations	<input type="checkbox"/> Heart problems	<input type="checkbox"/> Vision problems (glasses, contacts)
<input type="checkbox"/> Bone/muscle/joint problems	<input type="checkbox"/> Hemophilia	<input type="checkbox"/> Other _____
<input type="checkbox"/> Blood problems	<input type="checkbox"/> Juvenile arthritis	<input type="checkbox"/> Other _____
<input type="checkbox"/> Bowel/bladder problems	<input type="checkbox"/> Lead poisoning	<input type="checkbox"/> Other _____
<input type="checkbox"/> Cancer	<input type="checkbox"/> Migraines	<input type="checkbox"/> Other _____
<input type="checkbox"/> Cystic fibrosis	<input type="checkbox"/> Neuromuscular disorder	<input type="checkbox"/> Other _____

Please explain any conditions above or any reasons for hospitalizations.

Please indicate any allergies your child may have.

Allergy type	Reaction	School restrictions or recommended actions
<input type="checkbox"/> Bee/Insect		
<input type="checkbox"/> Food		
<input type="checkbox"/> Medication		
<input type="checkbox"/> Other		

# Health History continued

Please list any prescription and over the counter medication that your child takes on a regular basis.

Medication and dose	Time	Reason

Do any health and/or medical conditions require school restrictions, modifications, and/or intervention?  
 Yes    No   If YES, please explain.

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Does the student require any special procedures and/or treatments for their health condition(s)?  
 Yes    No   If YES, please explain.

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Please indicate any other information about your child's health or development that you think would be helpful for the school to know.

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Form completed by	Relationship to student	Date /   /
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Over please →

# PHYSICAL EXAMINATION

Student's name		Sex <input type="checkbox"/> Male <input type="checkbox"/> Female		Date of birth / /	
Height	Weight	BMI percentile		BP	

### Screening Tests

Vision	Hearing	Postural
Date performed / /	Date performed / /	Date performed / /
Distance Acuity <input type="checkbox"/> R <input type="checkbox"/> L Muscle Balance <input type="checkbox"/> Pass <input type="checkbox"/> Fail Stereopsis <input type="checkbox"/> Pass <input type="checkbox"/> Fail Color <input type="checkbox"/> Pass <input type="checkbox"/> Fail Child wears glasses? <input type="checkbox"/> Yes <input type="checkbox"/> No Tested with glasses? <input type="checkbox"/> Yes <input type="checkbox"/> No Referral made? <input type="checkbox"/> Yes <input type="checkbox"/> No	Pure Tone Right ear <input type="checkbox"/> Pass <input type="checkbox"/> Fail Left ear <input type="checkbox"/> Pass <input type="checkbox"/> Fail Child wears hearing aid? <input type="checkbox"/> Yes <input type="checkbox"/> No Child under the care of a hearing specialist? <input type="checkbox"/> Yes <input type="checkbox"/> No Referral made? <input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> No abnormality noted <input type="checkbox"/> Screening not done <input type="checkbox"/> Referral made Comments _____ _____ _____

<b>Speech/Language</b> Speech assessment completed <input type="checkbox"/> Yes <input type="checkbox"/> No Child has no discernible speech problem <input type="checkbox"/> Yes <input type="checkbox"/> No Speech evaluation recommended <input type="checkbox"/> Yes <input type="checkbox"/> No Child has possible problem with _____	<b>Lead Poisoning</b> <input type="checkbox"/> Date _____ Type <input type="checkbox"/> C <input type="checkbox"/> V Results _____ µg/dL <input type="checkbox"/> Date _____ Type <input type="checkbox"/> C <input type="checkbox"/> V Results _____ µg/dL <b>Tuberculin Test</b> Date _____ Type _____ Results _____	<b>HCT Results</b> PRESCHOOL ONLY _____
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**Health History (Serious or chronic illnesses/injuries/surgeries)**

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**Physical Examination** Date of most recent examination / /

Essentially normal       Abnormalities as follows \_\_\_\_\_

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Is this child able to participate fully in:

Classroom and academic activities	<input type="checkbox"/> Yes <input type="checkbox"/> No	Physical education classes	<input type="checkbox"/> Yes <input type="checkbox"/> No
Competition athletics	<input type="checkbox"/> Yes <input type="checkbox"/> No	Contact and collision sports	<input type="checkbox"/> Yes <input type="checkbox"/> No

If limitations are advised, please specify \_\_\_\_\_

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Does this child have any physical, developmental or behavioral issues that may affect his/her educational process?

\_\_\_\_\_

\_\_\_\_\_

Health Care Provider's signature	Print name	Phone (    )
Address		Date / /
City	State	Zip

# Ohio Department of Health • School and Adolescent Health Immunization Report

Student's name	Sex <input type="checkbox"/> Male <input type="checkbox"/> Female	Date of birth /   /
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Students are required to be immunized in accordance with Ohio law (Ohio Revised Code 3313.67/3313.671).  
 A copy of the child's immunization record may be attached or dates may be entered below.  
 Please note the month, day, and year for each immunization should be on record.

Vaccine	Record complete dates (month, day, year) of vaccine doses given					
Diphtheria, Tetanus, Pertussis (DTP)						
DTaP, Tdap						
DT, Td						
Polio						
Hepatitis B (HBV)						
Measles, Mumps, Rubella (MMR)						
Varicella (Chickenpox)						
Hepatitis A						
Meningococcal (MCV4, MPSV4)						
Pneumococcal (PCV)						
Measles (Rubeola) only						
Rubella only						
Mumps only						
Haemophilus influenza Type b (Hib)						
Influenza						
Other						

This information was provided by    Health Care Provider    Parent/Guardian    Other \_\_\_\_\_

Signature	Print name	Date /   /
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