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Withdrawn _____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 work phone		Father's home phone		
Mother's name				
Mother's address				
Mother's work phone		Mother's home phone		
With whom does child live?	name		address	
Who is this child's legal guardian?				

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

Type	Date					
DPT	/ /	/ /	/ /	/ /	/ /	/ /
TD	/ /	/ /	/ /	/ /	/ /	/ /
Polio	/ /	/ /	/ /	/ /	/ /	/ /
Measles (Rubeola)	/ /	/ /				
Rubella	/ /	/ /				
Mumps	/ /	/ /				
MMR Combined	/ /	/ /				
Other (Identify)	/ /	/ /	/ /	/ /	/ /	/ /

Child Health History, Continued:

Required compulsory immunization information law: 4 DPT; 3 polio; 1 measles, mumps, rubella (MMR) vaccine on or after child's first birthday.

Tuberculin test (latest)	☐ negative	Initial immunization information provided by: date
date / /	☐ positive	

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

- ☐ Abnormal spinal curvature (scoliosis, etc.)
- ☐ Allergies or hayfever
- ☐ Anemia
- ☐ Asthma or wheezing
- ☐ Bedwetting at night
- ☐ Behavior problem
- ☐ Birth or congenital malformation
- ☐ Cancer, type _____
- ☐ Chicken pox
- ☐ 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 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 ✓

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:
Relationship to child

Ohio School Health Record
Dentist's Report

The following services have been performed:

- ☐ Examination
- ☐ Diagnosis
- ☐ Radiographs
- ☐ Oral prophylaxsis
- ☐ Prescription for fluoride supplements
- ☐ Topical application of fluoride

The following oral hygiene instruction was provided:

- ☐ Toothbrushing
- ☐ Flossing
- ☐ Diet counseling reflecting relation of diet to dental health
- ☐ Home /school use of fluoride mouthrinse

The following statements are applicable:

- ☐ All necessary services have been performed
- ☐ No restorative services are required at this time
- ☐ Further treatment is indicated
- ☐ Further appointments have been arranged

Comments: _____

_____

_____

_____

_____

PLEASE PRINT OR STAMP

Dentist's name	Dentist's signature
Address	
	Date signed
Phone	