Ohio Department of Health • School and Adolescent Health

Health History

Student's name	Sex	Date of birth
	☐ Male ☐ Female	/ /

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? ☐ Yes ☐ No

Was infant born full term? ☐ Yes ☐ No Did the infant have any sickness or problems? ☐ Yes ☐ 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?

☐ About the same ☐ Delayed ☐ Advanced

Student Health Conditions

☐ **YES,** my child receives regular medical/health care for the following conditions: ☐ **NO** medical conditions

☐ Allergies	☐ Diabetes	☐ Seizure disorder
☐ Asthma	☐ Depression	☐ Sickle cell anemia
☐ ADD/ADHD	☐ Ear problem/hearing difficulty	☐ Skin conditions
☐ Autism	☐ Emotional concerns	☐ Speech problems
☐ Behavior concerns	☐ Headaches	☐ Traumatic brain injury
☐ Birth/congenital malformations	☐ Heart problems	☐ Vision problems (glasses, contacts)
☐ Bone/muscle/joint problems	☐ Hemophilia	☐ Other_____
☐ Blood problems	☐ Juvenile arthritis	☐ Other_____
☐ Bowel/bladder problems	☐ Lead poisoning	☐ Other_____
☐ Cancer	☐ Migraines	☐ Other_____
☐ Cystic fibrosis	☐ Neuromuscular disorder	☐ 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
☐ Bee/Insect		
☐ Food		
☐ Medication		
☐ 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.

Does the student require any special procedures and/or treatments for their health condition(s)?

☐ Yes ☐ No If YES, please explain.

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

Form completed by	Relationship to student	Date
		/ /

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Immunization Report

Student's name	Sex	Date of birth
	☐ Male ☐ Female	/ /

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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Physical Examination

Student's name	Sex ☐ Male ☐ Female	Date of birth / /

Height	Weight	BMI percentile	BP

Screening Tests

Vision

Date performed / /

Distance Acuity	☐ R	☐ L
Muscle Balance	☐ Pass	☐ Fail
Stereopsis	☐ Pass	☐ Fail
Color	☐ Pass	☐ Fail
Child wears glasses?	☐ Yes	☐ No
Tested with glasses?	☐ Yes	☐ No
Referral made?	☐ Yes	☐ No

Hearing

Date performed / /

Pure Tone		
Right ear	☐ Pass	☐ Fail
Left ear	☐ Pass	☐ Fail
Child wears hearing aid?	☐ Yes	☐ No
Child under the care of a hearing specialist	☐ Yes	☐ No
Referral made?	☐ Yes	☐ No

Postural

Date performed / /

☐ No abnormality noted
☐ Screening not done
☐ Referral made
Comments
_____
_____
_____

Speech/Language

Speech assessment completed	☐ Yes	☐ No
Child has no discernible speech problem	☐ Yes	☐ No
Speech evaluation recommended	☐ Yes	☐ No

Child has possible problem with _____

Lead Poisoning

☐ Date _____ Type ☐ C ☐ V Results_____ µg/dL
☐ Date _____ Type ☐ C ☐ V Results_____ µg/dL

Tuberculin Test

Date_____ Type _____ Results_____

Health History (Serious or chronic illnesses/injuries/surgeries)

_____

Physical Examination Date of most recent examination / /

☐ Essentially normal ☐ Abnormalities as follows

_____

_____

Is this child able to participate fully in:

Classroom and academic activities	☐ Yes	☐ No	Physical education classes	☐ Yes	☐ No
Competition athletics	☐ Yes	☐ No	Contact and collision sports	☐ Yes	☐ No

If limitations are advised, please specify

_____

_____

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

_____

_____

HealthCare Provider's signature	Print name	Phone ( )
Address		Date / /
City	State	ZIP

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Oral Assessment

Student's name	Date of birth
	/ /

The following services have been performed (please check all that apply)

☐ Examination ☐ Fluoride application ☐ Oral prophylaxis (cleaning) ☐ Prescription for fluoride supplement
☐ Orthodontic assessment ☐ Radiographs ☐ Dental sealant ☐ Treatment (restoration, pulp therapy)
☐ Other_____

The following oral hygiene instruction was provided (please check all that apply)

☐ Toothbrushing ☐ Flossing ☐ Dietary counseling ☐ Use of fluoride mouthrinse
☐ Other_____

The following statements are applicable (please check all that apply)

☐ All necessary preventive services have been performed. (Fluoride treatment, prophylaxis)
☐ No restorative services are required at this time.
☐ Further treatment is indicated.(See comments)
☐ Further appointments have been arranged. (Orthodontic, restorative)
☐ Routine recall visits recommended.

Comments

Dentist's signature	Print name	Phone ( )
Address		Date / /
City	State	ZIP