Ohio School Health History Form

School: _____

Holgate Local Schools

Please complete in blue or black ink Date Enrolled:_____Grade_____

_____

Student's Legal Last Name First Name Middle Name

Student's Address:_____ Female_____ Male_____

_____ Date of Birth____/____/_____

Father's Name _____

Father's Address _____

Home Phone _____Cell Phone _____Work Phone_____

Mother's Name _____

Mother's Address _____

Home Phone _____Cell Phone _____Work Phone_____

With whom does child live?_____

Who is this child's legal guardian?_____

Family History: Please list first and last names of all child's brothers and sisters

Name	Birthdate	Gender M/F	Health Concerns? Yes/No	Is the child in school? Yes/No	If so, where?
1.					
2.					
3.					
4.					
5.					

Perinatal History

Did the mother have any unusual physical or emotional illness during this pregnancy?

_____yes _____no if yes, explain briefly_____

Age of mother at this child birth_____ this infant was: ___full term ___early ___late birth weight_____

Did this 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's such as siblings or playmates?

_____ about the same _____ slower _____ faster

IMMUNIZATIONS

Please list the dates of the following immunizations (month / day / year)

DTAP DPT or DT						
Polio						
MMR (measles, mumps, rubella)						
Hepatitis B						
Varicella						
HIB (Haemophilus influenzae type b)						
Hepatitis A						
Other:_____						

NOTE: A copy of your child's immunizations record may be attached to this form

Allergies: Please list and describe the student's allergies and reactions

Medications:
Foods/Plants/Animals/Other:
Recommended treatment by school staff if allergy is severe:

Health Conditions: please check any condition that the student currently has or has had in the past.

__Abnormal Spinal curve (scoliosis)
__Allergies/Hayfever
__Anemia
__Asthma
__Attention Deficit Hyperactivity Disorder
__Autism
__Bee sting allergy
__Birth or congenital malformation
__Cancer, type_____
__Chicken Pox
__Chronic diarrhea or constipation
__Cystic Fibrosis
__Diabetes
__Eczema or other skin problems
__Emotional and/or Behavioral problems
__Eye problems, poor vision
__Frequent Headaches
__Frequent sore throats
__Hearing Difficulties
__Heart Disease: type_____
__Hemophilia
__Hepatitis: type_____
__Incontinence/ daytime soiling or wetting
__Juvenile Arthritis
__Kidney Disease
__Meningitis or Encephalitis
__Muscle Problems
__Near Drowning/Near Suffocation
__Nervous twitches or tics
__Poisoning
__Rheumatic Fever
__Seizure disorder/Epilepsy
__Sickle Cell Disease
__Speech Difficulties
__Substance Abuse (alcohol, drugs, tobacco)
__Toothaches or Dental problems
__Tourette Syndrome
__Urinary Tract Infection

Injuries, Illnesses, & Hospitalizations

Please list the student's severe injuries, illnesses and hospitalizations including inpatient and outpatient surgical procedures and emergency room visits.

Injuries, Illnesses, & Hospitalizations	**Age**	**If hospitalized, please explain**

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