**Ohio Department of Health ● School and Adolescent Health**

# Health History

| Student's name | Gender<br>Male Female | Date of birth<br>/ / |
|---|---|---|

## Family Health History

Please list allergies, heart problems, diabetes, cancer or other serious health conditions.

| |
|---|
| Father: |
| Mother: |
| Siblings: |

## Birth and Developmental History

No unusual birth or developmental history

Did the mother have any unusual physical or emotional illness during the 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 ☐ Advances

## Student Health Conditions

Does your child receive regular medical/health care for the following 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 reason for hospitalization.

## Health History continued

Please indicate any allergies your child may have. ☐ **NO Allergies**

| Allergy type | Reaction | School restrictions or recommended actions |
|---|---|---|
| ☐ Bee/Insect | | |
| ☐ Food | | |
| ☐ Medication | | |
| ☐ Other | | |

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

| Medication and dose | Time | Reason |
|---|---|---|
| | | |
| | | |
| | | |
| | | |
| | | |

Does your child have any physical education class restrictions? ☐ Yes ☐ No

If YES, please explain.

Do any health and/or medical conditions require school restrictions, modifications and/or intervention? ☐ 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.

Students are required to be immunized in accordance with Ohio law (Ohio Revised Code 3313.67/3313.671).

**A copy of your child's immunization record must be on file within 14 days of the first day of attendance in order for that child to remain in school.**

| Form completed by: | Relationship to student | Date / / |
|---|---|---|
| | | |

**I give permission for release of information on this form for confidential use in meeting my child's health and educational needs in school.**

**Signature** ***X***________________________________________ Date ____________