OHIO SCHOOL HEALTH HISTORY SCHOOL_____Date_____
To be completed by parent or guardian

Child's Full Name_____Social Security #_____
Last First Middle
Male____Female____Birth date (Month, day, year)_____

Child's Address_____
Father's Name_____Home phone_____
Father's Address_____
Father's Workplace_____Work phone_____
Mother's Name_____Home phone_____
Mother's Address_____
Mother's Workplace_____Work phone_____
With whom does the child Live?_____Relationship_____
Who is the child's legal guardian?_____Relationship_____

FAMILY HISTORY

Sibling	Birth date	Sex	Sibling	Birth date	Sex
1.			5.		
2.			6.		
3.			7.		
4.			8.		

PERINATAL HISTORY

Did the mother have any unusual physical or emotional illness during this pregnancy? YES/NO
If yes, explain briefly._____
How old was mother when this child was born?_____Birth weight_____
Was this infant: Pre-term_____ Full term_____ Overdue_____Weeks of gestation_____
Did the infant have any sickness or problems in the nursery? YES/NO If yes, please explain:
_____
_____

DEVELOPMENTAL HISTORY

At what approximate age did this child: Walk alone_____Age toilet trained_____
Spoke in sentences_____Dressed self_____
How does this child's development compare to other children, such as his/her siblings or playmates?
About the same_____Slower_____ Faster_____
Do you have any concerns about you child's development?_____
_____
This child is usually: Very active_____Normally active_____ Rather inactive_____
Does your child always wear seatbelts in the car? Yes_____No_____
PLEASE COMPLETE YOUR CHILD'S HEALTH HISTORY ON OTHER SIDE OF PAPER.

II. HEALTH CONDITIONS - Please check any that apply to your child and record the date of the illness.

_____Abnormal spinal curvature(Scoliosis)
_____Allergies, to what_____
_____
_____Anemia
_____Arthritis
_____Asthma, medication?_____
_____
_____Bed wetting at night
_____Behavior problem, describe_____
_____
_____Birth or congenital malformation?
_____
_____Cancer, type?_____
_____Chicken Pox, Date_____
_____Cystic Fibrosis
_____Diabetes, type_____
_____
_____Eczema
_____Emotional problems
_____Eye problems, glasses Yes/No
_____Frequent headaches
_____Frequent skin infections
_____Frequent sore throats, infections
_____Heart disease, type_____
_____Hepatitis, type_____
_____Kidney disease, type_____
_____Lead poisoning
_____Measles (Old fashioned/10 day)
_____Meningitis or Encephalitis
_____Multiple ear infections, age_____
Tubes, when?_____
_____Mumps
_____Near drowning or suffocation
_____Nervous twitch or tic
_____Poisoning, what type?_____
_____
_____Poor hearing
_____Rheumatic Fever
_____Seizures or epilepsy, type_____
_____
_____Sickle cell disease
_____Soiling or stooling of pants
_____Substance abuse, type_____
_____Suicide attempt
_____Toothaches or dental infections,
Last check-up_____
_____Urinary tract infections
_____Wetting during the day

II. ALLERGIES - Please list and describe allergies or reactions to:
Medications/drugs_____
Foods/plants/animals/bee stings _____
Recommended treatments_____

III. INJURIES AND ILLNESSES - Please list any severe injuries or illnesses:
1. _____
2. _____
3. _____

IV. ADDITIONAL INFORMATION:
What medications are given daily?_____
What medications are given frequently, not daily?_____
Do you have any concerns about how your child gets along with other children?_____
_____
Any other concerns you would like the school to be aware of?_____
_____
_____

Health History Informed Consent

The disclosure of student health information within the school is limited to the information necessary to serve the student's health and education interest. Your signature gives permissions for the nurse to inform school staff of precautions and procedures to protect your child in the classroom and to foster academic success.

Your signature is an informed consent to share this health history with the school staff on a need-to-know basis for academic success and emergency plans, as determined by the nurse.

X_____ _____
Parent/Guardian Signature Phone Number Date