

## **OHIO SCHOOL HEALTH HISTORY**

### **Instructions:**

1. A parent or guardian must complete pages 1-3.
2. A physician must fill out and sign pages 4-5.
3. The oral assessment on page 6 is optional, but highly recommended.
4. Please document on the health history form and inform the school nurse if your child has any health problems, allergies, or will be taking medication at school. If your child has an allergy, please have your physician document the prescribed treatment on the Physical Assessment form or appropriate medication form. Please inform the district nurse if your child takes medication at home.
5. Please attach a copy of your child's immunization records to this Ohio School Health History.
6. Vision and Hearing Screenings of all Kindergarten students will be done next fall. Parents will be notified by a written referral if your child will need further medical evaluation.

# Ohio School Health History

To be used for Pre-and Elementary School

School \_\_\_\_\_

Enrolled \_\_\_\_\_

Child's Name	Gender <input type="checkbox"/> Male <input type="checkbox"/> Female	Age	Birthdate
Name of child's parent/legal guardian/s? _____			
Parent/Guardian address _____			
Home Phone number _____			
Ethnicity <input type="checkbox"/> Caucasian <input type="checkbox"/> African American <input type="checkbox"/> Hispanic <input type="checkbox"/> Asian American <input type="checkbox"/> Other			

## Social Service History

Mark the box if you have contact with any of the following agencies:

- Child/Protective Services    If yes, Case worker's name \_\_\_\_\_
- Legal/Court System
- Family Counseling Services
- Mental Health Provider
- Other: \_\_\_\_\_

Mark the box if you or your child receive any of the following medical assistance:

- SSI, Disability
- Healthy Start
- Insurance (Blue Cross/Blue Shield, HMO)
- LEAP
- Medicaid/CHIP
- Other

## Family History

Please list the first and last name of all the child's family members including parents and siblings.

Name	Birthdate	Gender	Health Concerns	Is the child in school?	If so, where?

## Perinatal History

Did the mother have any unusual physical or emotional illness during this pregnancy? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, explain briefly _____
How old was the mother when the child was born? _____ What was the infant's birth weight?    _____ lbs.    _____ oz. <input type="checkbox"/> Full term <input type="checkbox"/> Early <input type="checkbox"/> Late
Did the infant have any sickness or problems? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, explain briefly _____

## Developmental History

Please give the approximate age at which this child:

Walked alone \_\_\_\_\_ Spoke in sentences \_\_\_\_\_

Toilet trained \_\_\_\_\_ Dressed self \_\_\_\_\_

How does this child's development compare to other children, such as his/her siblings or playmates?

- About the same                       Delayed                       Advanced

## Allergies

Please list and describe allergies and reactions

Medications/Drugs
Foods/plants/animals/other
Recommended treatment if allergy is severe

## Injuries, Illnesses and Hospitalizations

Please list any severe injuries, illnesses and hospitalizations including inpatient and outpatient surgical procedures

Injuries/Illness/Hospitalizations	Age	If hospitalized, please explain

Does your child always wear a seatbelt while riding in automobiles?       Yes       No

Does the student wear a helmet when bicycling, skating/rollerblading or riding a motorcycle?       Yes       No

## Medication Information

Please describe any medications that your child takes daily and/ or frequently.

Medication	What is the medication taken for?	How often is the medication taken? What time is the medication administered?

## Health Conditions

Please check any medical conditions that the child currently has or has had in the past.

- |  |  |
|--|--|
| <input type="checkbox"/> Abnormal spinal curvature (Scoliosis)           | <input type="checkbox"/> Hemophilia                      |
| <input type="checkbox"/> Allergies/hayfever                              | <input type="checkbox"/> Hepatitis                       |
| <input type="checkbox"/> Anemia  | <input type="checkbox"/> HIV positive                    |
| <input type="checkbox"/> Anaphylactic reaction                           | <input type="checkbox"/> Hyperactivity                   |
| <input type="checkbox"/> Asthma or wheezing                              | <input type="checkbox"/> Juvenile Arthritis              |
| <input type="checkbox"/> Attention deficit disorder (ADD)                | <input type="checkbox"/> Kidney disease type_____        |
| <input type="checkbox"/> Behavior problem                                | <input type="checkbox"/> Measles (10 day)                |
| <input type="checkbox"/> Birth or congenital malformation                | <input type="checkbox"/> Meningitis or Encephalitis      |
| <input type="checkbox"/> Cancer type_____                                | <input type="checkbox"/> Mumps                           |
| <input type="checkbox"/> Chickenpox when_____                            | <input type="checkbox"/> Mutism                          |
| <input type="checkbox"/> Chronic Diarrhea or constipation                | <input type="checkbox"/> Near-drowning/Near-suffocation  |
| <input type="checkbox"/> Chronic ear infections                          | <input type="checkbox"/> Nervous twitches or tics        |
| <input type="checkbox"/> Concern about relation with siblings or friends | <input type="checkbox"/> Poisoning                       |
| <input type="checkbox"/> Cystic Fibrosis                                 | <input type="checkbox"/> Rheumatic fever                 |
| <input type="checkbox"/> Diabetes  | <input type="checkbox"/> Seizure disorder/Epilepsy       |
| <input type="checkbox"/> Eczema/Chronic skin conditions                  | <input type="checkbox"/> Sickle Cell Disease             |
| <input type="checkbox"/> Emotional Problems                              | <input type="checkbox"/> Speech difficulties             |
| <input type="checkbox"/> Eye problems, poor vision                       | <input type="checkbox"/> Stool soiling                   |
| <input type="checkbox"/> Frequent headaches                              | <input type="checkbox"/> Toothaches or dental problems   |
| <input type="checkbox"/> Frequent sore throats                           | <input type="checkbox"/> Tourette's Syndrome             |
| <input type="checkbox"/> Heart disease type_____                         | <input type="checkbox"/> Urinary tract infections        |
|  | <input type="checkbox"/> Wetting during the day or night |

## Behavioral History

The child is usually:  very active  normally active  rather inactive

Has your child ever been violent or acted out in the following manner towards adults or children:

- hitting  kicking  biting  fighting  scratching

Do you have any concern about how your child gets along with other children?

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Please add any comments or concerns you have about your child's health, development, behavior, family or home life that you would like the school to be aware of.

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Is the student enrolled in a special education course?  Yes  No

If yes, please list \_\_\_\_\_

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Parent/Guardian Signature

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Date

## **Instructions for the following Health forms:**

1. Please take pages 4 and 5 (Physical Assessment) with you to your physician at the time of your child's physical. This physical form must be returned to Perry Elementary School's office prior to the first day of school.
2. Please take page 6 (Oral Assessment) to your dentist when your child has his/her yearly check-up and cleaning. This is optional, but highly recommended.
3. A green Request to Administer Medications form must be complete for ALL medications given at school. This includes over-the-counter medications (Tylenol, Advil, Benadryl and Tums, etc.)
  - a.) If you feel your child will need to visit the clinic for Tylenol, Advil, Benadryl Tums during the course of the school year, please complete **both sides**, excluding the prescriber signature box, of the attached form (Request to Administer Medications). You are welcome to drop off a supply of over-the-counter medications to the clinic for the entire year with the completed form.
  - b.) If your child will need prescription medication, please complete the **front and back** of the Request to Administer Medications form along with the **required prescriber's signature**.

**All medications must be in the original container and be delivered by an adult to the school nurse.**

If you have any questions, please contact the district nurse at 259-9600 x9671 or x9672.

Healthy Regards,

Sandy Yankie RN  
Fran Keller RN

# Ohio School Health History

## Physical Assessment

School \_\_\_\_\_

Enrolled \_\_\_\_\_

Child's Name	Gender	Age	Birthdate
	<input type="checkbox"/> Male <input type="checkbox"/> Female		
Ethnicity			
<input type="checkbox"/> Caucasian	<input type="checkbox"/> African American	<input type="checkbox"/> Hispanic	<input type="checkbox"/> Asian American <input type="checkbox"/> Other

### Objective Data

Height	Weight	B.P.
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### Immunizations

Type	Date    Mo/Day/Yr				
<b>DTaP DPT or DT</b>					5 <sup>th</sup> dose required if 4 <sup>th</sup> dose given before age 4
<b>DT/Td</b>					
<b>POLIO</b>					4 doses any combination, final dose must be given on or after 4 <sup>th</sup> birthday
<b>MMR</b>					2 doses required for K
<b>HEPATITIS B</b>					3 doses required for K
<b>VARICELLA</b>					2 doses required for K
<b>HIB</b> (prior to age 5 only)					0-14 months; 3-4 doses 15-59 months: 1 dose
<b>TUBERCULIN TEST</b>					
<b>ROTAVIRUS</b> (given @ 2-4-6 mo, not after 12 months)					
<b>OTHER</b>					

### Screening Tests

Vision	Date	Hearing	Date
Distance Acuity Right _____ Left _____		Pure tone testing:	
Muscle Balance <input type="checkbox"/> Pass <input type="checkbox"/> Fail <input type="checkbox"/> Not Done		Right ear <input type="checkbox"/> Pass <input type="checkbox"/> Fail <input type="checkbox"/> Not Done	
Farsightedness <input type="checkbox"/> Pass <input type="checkbox"/> Fail <input type="checkbox"/> Not Done		Left ear <input type="checkbox"/> Pass <input type="checkbox"/> Fail <input type="checkbox"/> Not Done	
Color <input type="checkbox"/> Pass <input type="checkbox"/> Fail <input type="checkbox"/> Not Done		Child wears hearing aid? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Child wears glasses? <input type="checkbox"/> Yes <input type="checkbox"/> No		Testing with hearing aid? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Tested with glasses? <input type="checkbox"/> Yes <input type="checkbox"/> No		Referral made? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Referral made? <input type="checkbox"/> Yes <input type="checkbox"/> No		Other test (specify) _____	
Specify Test/Equipment			

<b>Speech Assessment</b>	Date
<input type="checkbox"/> Child has no discernible speech problem <input type="checkbox"/> Child has possible problem with: <input type="checkbox"/> Articulation <input type="checkbox"/> Rhythm <input type="checkbox"/> Voice <input type="checkbox"/> Language Speech evaluation is recommended: <input type="checkbox"/> Yes <input type="checkbox"/> No	

## Laboratory Tests

<input type="checkbox"/> Hemoglobin/Hematocrit	<input type="checkbox"/> Urine Protein	<input type="checkbox"/> Urine blood	<input type="checkbox"/> Urine glucose
<input type="checkbox"/> Other _____			

## Physical Examination

Date of Examination: \_\_\_\_\_

This child is essentially within normal limits.

This child is not within normal limits.

Explain:

Does this child have any physical, developmental or behavioral problems? Suggest special programs, placement or attention that the school can provide.

### Activities & Limitations

Can the child participate fully in the following activities:

Classroom and academic activities  Yes  No

Physical education classes  Yes  No

Competitive athletics  Yes  No

Contact and collision sports  Yes  No

Specify any limitations:

Is this child on any medications?  Yes  No

Explain:

Examiner's Signature \_\_\_\_\_ Date Signed \_\_\_\_\_

Examiner's Printed Name \_\_\_\_\_

Address \_\_\_\_\_  
\_\_\_\_\_

Phone \_\_\_\_\_

# Ohio School Health History

## Oral Assessment

School \_\_\_\_\_

Enrolled \_\_\_\_\_

Child's Name	Gender	Age	Birthdate
	<input type="checkbox"/> Male <input type="checkbox"/> Female		

The following services have been performed:

- Examination by dentist
- Orthodontic assessment
- Oral screening
- Dental sealants
- Radiographs
- Fluoride Application
- Oral Prophylaxis (cleaning)
- Diagnosis
- Prescription for fluoride supplements

The following oral hygiene instruction was provided:

- Toothbrushing
- Diet counseling related to dental health
- Flossing
- Home/school use of fluoride mouth rinse

The following statements are applicable:

- No apparent care needed at this time.
- 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. (ex. Orthodontic, restorative)

Comments:

Examiner's Signature \_\_\_\_\_ Date Signed \_\_\_\_\_

Examiner's Printed Name \_\_\_\_\_

Address \_\_\_\_\_  
\_\_\_\_\_

Phone \_\_\_\_\_