

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.



VACCINES	FALL 2022 Immunizations for School Attendance
DTaP/DT Tdap/Td Diphtheria, Tetanus, Pertussis	<p>K-12 Four or more doses of DTaP or DT, or any combination. If all four doses were given <i>before the fourth birthday</i>, a fifth dose is <i>required</i>. If the fourth dose was administered at least six months after the third dose, and on or after the fourth birthday, a fifth dose is not required.*</p> <p>Grades 1-12 Three doses of Td or a combination of Td and Tdap is the minimum acceptable for children ages 7 years and older with the first dose being Tdap. Minimum spacing of four weeks between doses 1 and 2, and six months between doses 2 and 3.</p> <p>Grade 7 One dose of Tdap vaccine must be administered on or after the 10th birthday. ** All students in grades 8-12 must have one documented Tdap dose.</p>
POLIO	<p>K-12 Three or more doses of IPV. <i>The FINAL dose must be administered on or after the fourth birthday</i>, regardless of the number of previous doses and there must be six months spacing between doses 2 and 3. If a combination of OPV and IPV was received, four doses of either vaccine are required.</p>
MMR Measles, Mumps, Rubella	<p>K-12 Two doses of MMR. The first dose must be administered on or after the first birthday. The second dose must be administered at least 28 days after the first dose.</p>
HEP B Hepatitis B	<p>K-12 Three doses of hepatitis B. The second dose must be administered at least 28 days after the first dose. The third dose must be given at least 16 weeks after the first dose and at least eight weeks after the second dose. The last dose in the series (third or fourth dose) must not be administered before age 24 weeks.</p>
VARICELLA (Chickenpox)	<p>K-12 Two doses of varicella vaccine must be administered prior to entry. The first dose must be administered on or after the first birthday. The second dose should be administered at least three months after the first dose; however, if the second dose is administered at least 28 days after the first dose, it is considered valid.</p>
MCV4 Meningococcal	<p>Grade 7 One dose of meningococcal (serogroup A, C, W, and Y) vaccine <u>must be administered prior to seventh grade entry. All students grades 8-11 must have one documented dose of MCV4.</u></p> <p>Grade 12 Two doses of MCV4 by age 16 years, with a minimum interval of eight weeks between doses. If the first dose was given on or after the 16th birthday, only one dose is required. ****</p>

NOTES:

- Vaccine should be administered according to the most recent version of the *Recommended Child and Adolescent Immunization Schedule for ages 18 years or younger* or the *Catch-up immunization schedule for persons aged 4 months-18 years who start late or who are more than 1 month behind*, as published by the Centers for Disease Control and Prevention’s Advisory Committee on Immunization Practices. Schedules are available for print or download through www.cdc.gov/vaccines/schedules/index.html.
- Vaccine doses administered less than or equal to four days before the minimum interval or age are valid (grace period). Doses administered greater than or equal to five days earlier than the minimum interval or age are not valid doses and should be repeated when age appropriate. If MMR and varicella are **not** given on the same day, the doses must be separated by at least 28 days with no grace period.
- For additional information, please refer to the [Ohio Revised Code 3313.67](#) and [3313.671](#) for school attendance and the [ODH Director’s Journal Entry](#) on required vaccines for child care and school. These documents list required and recommended immunizations and indicate exemptions to immunizations.
- **Please contact the Ohio Department of Health Immunization Program at 800-282-0546 or 614-466-4643 with questions or concerns.**

* Recommended DTaP or DT minimum intervals for kindergarten students are four weeks between the first and second doses, and the second and third doses; and six months between the third and fourth doses and the fourth and fifth doses. If a fifth dose is administered prior to the fourth birthday, a sixth dose is recommended but not required.

** Tdap can be given regardless of the interval since the last tetanus or diphtheria-toxoid containing vaccine. Children age 7 years or older with an incomplete history of DTaP should be given Tdap as the first dose in the catch-up series. If the series began at age 7-9 years, the fourth dose must be a Tdap given at age 11-12 years. If the third dose of Tdap is given at age 10 years, no additional dose is needed at age 11-12 years.

*** The final polio dose in the IPV series must be administered at age 4 years or older with at least six months between the final and previous dose.

**** Recommended MCV4 minimum interval of at least eight weeks between the first and second doses. If the first dose of MCV4 was administered on or after the 16th birthday, a second dose is not required. If a pupil is in 12th grade and is 15 years old or younger, only one dose is required. Currently, there are no school entry requirements for meningococcal B vaccine.

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?

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.

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

If yes, please list _____

Parent/Guardian Signature

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

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			
Speech Assessment	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

Hemoglobin/Hematocrit

Urine Protein

Urine blood

Urine glucose

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:

- | | | |
|--|---|--|
| <input type="checkbox"/> Examination by dentist | <input type="checkbox"/> Orthodontic assessment | <input type="checkbox"/> Oral screening |
| <input type="checkbox"/> Dental sealants | <input type="checkbox"/> Radiographs | <input type="checkbox"/> Fluoride Application |
| <input type="checkbox"/> Oral Prophylaxis (cleaning) | <input type="checkbox"/> Diagnosis | <input type="checkbox"/> Prescription for fluoride supplements |

The following oral hygiene instruction was provided:

- | | |
|--|---|
| <input type="checkbox"/> Toothbrushing | <input type="checkbox"/> Diet counseling related to dental health |
| <input type="checkbox"/> Flossing | <input type="checkbox"/> 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 _____