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 you child takes medication at home.

5. 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.

Immunization Record must include.

• **DPT** (minimum of 4) – 5 doses if the 4th dose was administered prior to the 4th birthday.

• **Polio Vaccine** (minimum of 3) – 4 doses ***always*** if a combination of OPV or IPV was administered. 4 doses of all OPV or all IPV is required if the third dose of either vaccine was administered prior to the 4th birthday.

• **2 doses** of **MMR** (Measles (Rubeola), Rubella (3 day), plus Mumps)…**1st MMR** dose on or after 12 months of age…**2nd MMR** dose to be given at least 28 days after 1st dose but **must be given before starting Kindergarten.**

• **Hepatitis B (3 shot series)** must show evidence of having received a 3 dose series or proof that the Hepatitis B Series is in progress.

• Immunizations may be arranged with your physician or by making arrangements with the Health Department Office located at 33 Mill Street, Painesville, OH, phone 350-2554. **By State law, the immunization record for each student must be completed before the child comes to school in August. Please contact the school nurse if you have any questions at 259-9604.**

Ohio School Health History School _____

To be used for Pre-and Elementary School Enrolled _____

Child's Name Gender Age Birthdate

☐ Male ☐ Female

Name of child's parent/legal guardian/s?

_____

Parent/Guardian address

_____

Home Phone

number_____

Ethnicity

□ Caucasian □ African American □ Hispanic □ Asian American □ 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? □ Yes □ No

If yes, explain

briefly_____

How old was the mother when the child was born? _____

What was the infant's birth weight? _____lbs. _____oz. □ Full term □ Early □ Late

Did the infant have any sickness or problems? □ Yes □ 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.

☐ Abnormal spinal curvature (Scoliosis) ☐ Hemophilia

☐ Allergies/hayfever ☐ Hepatitis

☐ Anemia ☐ HIV positive

☐ Anaphylactic reaction ☐ Hyperactivity

☐ Asthma or wheezing ☐ Juvenile Arthritis

☐ Attention deficit disorder (ADD) ☐ Kidney disease type_____

☐ Behavior problem ☐ Measles (10 day)

☐ Birth or congenital malformation ☐ Meningitis or Encephalitis

☐ Cancer type_____ ☐ Mumps

☐ Chickenpox when _____ ☐ Mutism

☐ Chronic Diarrhea or constipation ☐ Near-drowning/Near-suffocation

☐ Chronic ear infections ☐ Nervous twitches or tics

☐ Concern about relation with siblings or friends ☐ Poisoning

☐ Cystic Fibrosis ☐ Rheumatic fever

☐ Diabetes ☐ Seizure disorder/Epilepsy

☐ Eczema/Chronic skin conditions ☐ Sickle Cell Disease

☐ Emotional Problems ☐ Speech difficulties

☐ Eye problems, poor vision ☐ Stool soiling

☐ Frequent headaches ☐ Toothaches or dental problems

☐ Frequent sore throats ☐ Tourette's Syndrome

☐ Heart disease type_____ ☐ Urinary tract infections

☐ 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

_____

Verification completed by: _____ 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 student 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 and 259-9504 or 259-9604.

Healthy Regards,

Sandy Yankie RN

Fran Keller RN

Ohio School Health History School _____

Physical Assessment Enrolled _____

Child's Name Gender Age Birthdate

☐ Male ☐ Female

Ethnicity

☐ Caucasian ☐ African American ☐ Hispanic ☐ Asian American ☐ Other

Objective Data

Height

Weight

B.P.

Immunizations

Type Date Mo/Day/Yr

DTaP DPT or DT 5th dose required if 4th dose given before age 4

DT/Td

POLIO 4th dose required if 3rd dose given before age 4

MMR 2nd dose required for K

HEPATITIS B 3 doses required for K

VARICELLA 1 dose 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_____

Muscle Balance ☐Pass ☐Fail ☐Not Done

Farsightedness ☐Pass ☐Fail ☐Not Done

Color ☐Pass ☐Fail ☐Not Done

Child wears glasses? ☐Yes ☐No

Tested with glasses? ☐Yes ☐No

Referral made? ☐Yes ☐No

Specify Test/Equipment

Pure tone testing:

Right ear ☐Pass ☐Fail ☐Not Done

Left ear ☐Pass ☐Fail ☐Not Done

Child wears hearing aid? ☐Yes ☐No

Testing with hearing aid? ☐Yes ☐No

Referral made? ☐Yes ☐No

Other test (specify) _____

Speech Assessment Date

☐ Child has no discernible speech problem

☐ Child has possible problem with: ☐ Articulation ☐ Rhythm ☐ Voice ☐Language

Speech evaluation is recommended: ☐Yes ☐ 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 School _____

Oral Assessment Enrolled _____

Child's Name Gender Age Birthdate

☐ Male ☐ 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 mouthrinse

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 ____