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

________________________________________________

Page 1
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

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**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

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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 __________________________
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 ________________________________________________________________________

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