Ohio School Health History

Pages 1-2 to be completed by parent or guardian

Pages 3-4 to be completed by physician and faxed to school branch

Tree of Life
CHRISTIAN SCHOOLS

Health History

To be Completed in full by Parent / Guardian

Child's Information

Last name	First name	Middle name		
Sex ☐ Male ☐ Female	Birthdate	Month	Day	Year
Father's Name				
Mother's Name				
With whom does child live?				
Who is child's legal guardian?				

Family History

Please list child's brothers and sisters

Name	Birthdate	Sex	Health Concerns?	Please explain.
		M F	Yes No	
		M F	Yes No	
		M F	Yes No	
		M F	Yes No	
		M F	Yes No	

Prenatal History

Did child's mother have any unusual physical or emotional illness during this pregnancy? ☐ No ☐ Yes If yes, explain briefly.			
Mother's age when child was born -	Was infant born: ☐ Full Term ☐ Early ☐ Late	Birth Weight?	lbs oz.
Did the infant have any sickness or problems while in the hospital nursery? ☐ No ☐ Yes If yes, explain briefly.			

Developmental History

Please give the approximate age at which this child:	Walked alone _____	Spoke in sentences _____
	Was toilet trained_____	Dressed self_____
How does this child's development compare to other children, such as sisters/brothers or playmates? ☐ Same ☐ Slower ☐ Faster		
This child is usually: ☐ Very active ☐ Normally active ☐ Rather inactive		

Allergies - Please list and describe student's allergies and specific reactions to allergens

Medications:
Foods / Plants / animals / other:
Recommended treatment by school staff if allergy is severe:

** If medications are part of the treatment, please ask for medication forms**

Health History Continued

1. Health Conditions - Please check any that student currently has or has had in the past

- ☐ Abnormal spinal curvature (scoliosis)
- ☐ Allergies/ Hayfever
- ☐ Anemia
- ☐ Asthma/wheezing
- ☐ ADD/ADHD
- ☐ Autism
- ☐ Bedwetting at night
- ☐ Bee sting allergy
- ☐ Behavior problem
- ☐ Birth or congenital malformation
- ☐ Bone/Muscle/Joint Problems
- ☐ Cancer: type_____
- ☐ Chicken Pox
- ☐ Chronic diarrhea or constipation
- ☐ Concern about relationship with siblings/friends
- ☐ Cystic Fibrosis
- ☐ Diabetes
- ☐ Eczema or other skin problems
- ☐ Emotional/behavioral problems
- ☐ Eye problems/poor vision
- ☐ Frequent Headaches
- ☐ Frequent skin infections
- ☐ Frequent sore throats
- ☐ Hearing Difficulties/ear problems
- ☐ Heart Disease: type_____
- ☐ Hemophilia
- ☐ Hepatitis: type_____
- ☐ Incontinence/Daytime soiling or wetting
- ☐ Juvenile Arthritis
- ☐ Kidney Disease
- ☐ Lead poisoning
- ☐ Measles(Old-fashioned 10 day)
- ☐ Meningitis or Encephalitis
- ☐ Mumps
- ☐ Muscle problems
- ☐ Near-drowning or near-suffocation
- ☐ Nervous twitches or tics
- ☐ Neuromuscular disorder
- ☐ Poisoning
- ☐ Pregnancy
- ☐ Rheumatic Fever
- ☐ Seizures/Epilepsy
- ☐ Sickle Cell Disease
- ☐ Speech Difficulties
- ☐ Substance Abuse (alcohol, drugs, tobacco)
- ☐ Suicide Attempt
- ☐ Toothaches or dental problems
- ☐ Tourette Syndrome
- ☐ Urinary Tract Infection
- ☐ Other_____
- ☐ Other_____
- ☐ Other_____

2. Injuries, Illnesses and hospitalizations - Please list the student's severe injuries, illnesses and hospitalizations including inpatient and outpatient surgical procedures and emergency room visits.

Age	Specify Circumstances	If Hospitalized, please explain.

3. Does child always wear seatbelt in cars? ☐ Yes ☐ No

4. Additional Information:

What medications are given daily? _____

Medications given frequently, but not daily _____

Do you have any concerns about how your child gets along with others? _____

Any other concerns about this child's health, development, behavior, family or home life that you would like the school to be aware of? Please explain. _____

Completed by:_____ **Relationship to child**_____**Date**_____

Tree of Life
CHRISTIAN SCHOOLS

Physician's Report
Ohio School Health Record

Child's Information

Full Name:	o Male o Female	Age	Birthdate

Objective Data

Height (%)	Weight (%)	B.P. /

Screening Tests

VISION	Date:			**HEARING**	Date:
Distance Acuity	Right_____	Left_____		Pur tone testing:	
				Right ear	oPass o Fail o Not done
Muscle Balance	oPass	oFail	o Not done	Left ear	oPass o Fail o Not done
Farsightedness	oPass	oFail	o Not done	Other tests (specify)	
Color	oPass	oFail	o Not done		
Child wears Glasses	oYes	o No		Child wears Hearing Aid	o Yes o No
Tested with Glasses	oYes	o No		Tested with Hearing Aid	o Yes o No
Referral Made	oYes	o No		Referral Made	o Yes o No

Speech/Language

Speech assessment	oDone	o Not done	o Child has no discernable speech problem	
Child has possible problem with	o Articulation	o Rhythm	oVoice	o Language
Speech evaluation recommended	oYes	o No		

Laboratory Tests

o Hematocrit/Hemoglobin	o Urine Protein	o Other_____
o Urine blood	o Urine glucose	o Other_____

Physical Examination

Date examined _____ o Essentially normal o Abnormalities as follows:_____

Is this child able to fully participate in the following:

Classroom and academic activities	oYes	o No	Physical Education Classes	o Yes o No
Competition athletics	oYes	o No	Contact/collision sports	o Yes o No

If limitations are advised, please specify _____

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Physician's Report (Continued)

If this child has any physical, developmental, or behavioral problems, how can the school assist with special programs, placement, or attention? _____

Immunization record (or attach immunization record)

Type	Date	Date	Date	Date	Date
DTaP	/ /	/ /	/ /	/ /	/ /
Tdap	/ /	/ /	/ /	/ /	
Polio	/ /	/ /	/ /	/ /	
MMR	/ /	/ /			
HIB	/ /	/ /	/ /	/ /	
Hepatitis B	/ /	/ /	/ /		
Varicella	/ /	/ /			
MCV4	/ /	/ /			
Hepatitis A	/ /	/ /			
Rotavirus	/ /	/ /	/ /		
Pneumococcal	/ /	/ /	/ /	/ /	/ /
Influenza	/ /	/ /	/ /	/ /	/ /
	/ /	/ /	/ /	/ /	/ /

Tuberculin Test - for <u>all students born outside of USA</u> and those who <u>have traveled to high risk country</u> in last 5 years

Date _____/_____ /_____ o Negative o Positive

If test is positive, include a chest X-Ray, Quantiferon TB blood test and doctor's note ruling out active TB.

Physician's Assessment

Problem List	Recommendation for School Management
1	
2	
3	
4	

Completed by (Please print or stamp)

Physician Name

Address

Phone

Fax

Physician's Signature **Date**

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