

**Ohio Department of Health • School and Adolescent Health**  
**Health History**

Student's name _____	Sex <input type="checkbox"/> Male <input type="checkbox"/> Female	Date of birth /      /
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**Family Health History** Please list allergies, heart problems, diabetes, cancer or other serious health conditions.

Father
Mother
Brothers and Sisters

**Birth and Developmental History**     No unusual birth or developmental history

Did the mother have any unusual physical or emotional illness during this pregnancy?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Was infant born full term? <input type="checkbox"/> Yes <input type="checkbox"/> No	Did the infant have any sickness or problems? <input type="checkbox"/> Yes <input type="checkbox"/> No
Briefly explain illness or problems. _____	
How does the child's development compare to other children, such as his or her brothers/sisters or playmates? <input type="checkbox"/> About the same <input type="checkbox"/> Delayed <input type="checkbox"/> Advanced	

**Student Health Conditions**

<input type="checkbox"/> <b>YES</b> , my child receives regular medical/health care for the following conditions:		<input type="checkbox"/> <b>NO</b> medical conditions
<input type="checkbox"/> Allergies	<input type="checkbox"/> Diabetes	<input type="checkbox"/> Seizure disorder
<input type="checkbox"/> Asthma	<input type="checkbox"/> Depression	<input type="checkbox"/> Sickle cell anemia
<input type="checkbox"/> ADD/ADHD	<input type="checkbox"/> Ear problem/hearing difficulty	<input type="checkbox"/> Skin conditions
<input type="checkbox"/> Autism	<input type="checkbox"/> Emotional concerns	<input type="checkbox"/> Speech problems
<input type="checkbox"/> Behavior concerns	<input type="checkbox"/> Headaches	<input type="checkbox"/> Traumatic brain injury
<input type="checkbox"/> Birth/congenital malformations	<input type="checkbox"/> Heart problems	<input type="checkbox"/> Vision problems (glasses, contacts)
<input type="checkbox"/> Bone/muscle/joint problems	<input type="checkbox"/> Hemophilia	<input type="checkbox"/> Other _____
<input type="checkbox"/> Blood problems	<input type="checkbox"/> Juvenile arthritis	<input type="checkbox"/> Other _____
<input type="checkbox"/> Bowel/bladder problems	<input type="checkbox"/> Lead poisoning	<input type="checkbox"/> Other _____
<input type="checkbox"/> Cancer	<input type="checkbox"/> Migraines	<input type="checkbox"/> Other _____
<input type="checkbox"/> Cystic fibrosis	<input type="checkbox"/> Neuromuscular disorder	<input type="checkbox"/> Other _____

Please explain any conditions above or any reasons for hospitalizations.  
 \_\_\_\_\_  
 \_\_\_\_\_

Please indicate any allergies your child may have.		School restrictions or recommended actions
Allergy type	Reaction	
<input type="checkbox"/> Bee/Insect		
<input type="checkbox"/> Food		
<input type="checkbox"/> Medication		
<input type="checkbox"/> Other		

# Health History continued

Please list any prescription and over the counter medication that your child takes on a regular basis.

Medication and dose	Time	Reason

Do any health and/or medical conditions require school restrictions, modifications, and/or intervention?

Yes    No   If YES, please explain.

Does the student require any special procedures and/or treatments for their health condition(s)?

Yes    No   If YES, please explain.

Please indicate any other information about your child's health or development that you think would be helpful for the school to know.

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Form completed by	Relationship to student	Date / /
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Phone Number	
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EpiPen In School	YES <input type="checkbox"/>	NO <input type="checkbox"/>
Inhaler In School	YES <input type="checkbox"/>	NO <input type="checkbox"/>

