

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 or her brothers/sisters or playmates?

___ About the same ___ Delayed ___ Advanced

Allergies

Please list and describe allergies or reactions.

Medications/drugs

Foods/plants/animals/other

Recommended treatment if allergy is severe

Injuries, Illness & 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 frequently.

Name of 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 | <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 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?

yes no If yes, explain _____

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. _____

To enter kindergarten, the child must have:

- DTP--5 doses of DTaP, DTP, or DT or any combination, if the fourth (4th) dose was administered before age 4;
- Polio--4 doses of any combination of OPV or IPV, the final does must be administered on or after the 4th birthday;
- MMR--2 doses. Dose 1 must be administered on or after the first birthday. The second must be administered at least 28 days after dose 1;
- Hepatitis B series of 3
- Chicken Pox--2 doses of Varicella (Chicken Pox) immunization. I dose if the child has had Chicken Pox. A note stating that is required to be kept in his/her file.

Parent/guardian signature

Date

Ohio School Health History

School _____
 Enrolled _____

Child's Name	Gender	Age	Birthdate
_____ male _____ female			
Ethnicity	_____ American Indian/Alaskan Native	_____ White (Non-Hispanic)	_____ Black (Non-Hispanic)
	_____ Hispanic	_____ Asian/Pacific Islander	_____ Multiracial

Objective Data

Height	Weight	B.P.

Immunizations Bolded boxes are required for school entry.						
Type	Date M/D/Y					
DTaP/DPT/Td	 	 	 	 	 	5 th dose required if 4 th dose given before age 4
POLIO	 	 	 	 	 	4 th dose required if 3 rd dose was given before age 4.
MMR	 	 	 	 	 	2 nd doses required for Kindergarten. Dose 1 must be administered on or after the first birthday. The second dose must be administered at least 28 days after dose 1.
HEPATITIS B	 	 	 	 	 	3 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 8 weeks after the second dose. The last dose in the series (3 rd or 4 th dose), must not be administered before age 24 weeks.
VARICELLA	 	 	 	 	 	2 doses 1 dose if child has had the Chicken Pox (a note stating that will be required for his/her file).
HIB (prior to age 5 only)	 	 	 	 	 	0-14 moths: 3-4 doses 15-59 months: 1 dose
TUBERCULIN TEST	 	 	 	 	 	
ROTAVIRUS <small>(given @ 2-4-6 mo, not after 12 months)</small>	 	 	 	 	 	
OTHER	 	 	 	 	 	

Screening Tests

Vision	Date	Hearing	Date
Distance Acuity _____ Right _____ Left		Pure tone testing:	
Muscle Balance _____ Pass _____ Fail _____ Not done		Right ear _____ Pass _____ Fail _____ Not done	
Farsightedness _____ Pass _____ Fail _____ Not done		Left ear _____ Pass _____ Fail _____ Not done	
Color _____ Pass _____ Fail _____ Not done		Child wears hearing aid _____ Yes _____ No	
Child wears glasses _____ Yes _____ No		Testing with hearing aid? _____ Yes _____ No	
Tested with glasses _____ Yes _____ No		Referral made? _____ Yes _____ No	
Referral made? _____ Yes _____ No			
Specify Test/Equipment _____		Other test (specify) _____	

Speech Assessment Date

<input type="checkbox"/> Child has no dissemble 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

<input type="checkbox"/> Hemoglobin/Hematocrit	<input type="checkbox"/> Urine protein	<input type="checkbox"/> Urine blood	<input type="checkbox"/> Urine glucose
<input type="checkbox"/> 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 & 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 _____
 Enrolled _____

Oral Assessment

Child's Name	Gender _____ male _____ female	Age	Birthdate
Ethnicity _____ Caucasian _____ African American	_____ Hispanic	_____ Asian American	_____ Other

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 mouthrinse |

The following statements are applicable:

- No apparent care needed at this time.
- All necessary preventive services have been performed. (Fluoride treatment, prophylaxia)
- 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 _____