

# 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 /    /
----------------	--	-------------------------

**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. <hr/>	
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. <hr/>		

Please indicate any allergies your child may have.

Allergy type	Reaction	School restrictions or recommended actions
<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.

---

---

---

---

---

---

Form completed by	Relationship to student	Date / /
-------------------	-------------------------	----------

# Physical Examination

Student's name		Sex <input type="checkbox"/> Male <input type="checkbox"/> Female		Date of birth / /	
Height	Weight	BMI percentile		BP	

## Screening Tests

Vision		Hearing		Postural	
Date performed / /		Date performed / /		Date performed / /	
Distance Acuity	<input type="checkbox"/> R <input type="checkbox"/> L	Pure Tone		<input type="checkbox"/> No abnormality noted	
Muscle Balance	<input type="checkbox"/> Pass <input type="checkbox"/> Fail	Right ear	<input type="checkbox"/> Pass <input type="checkbox"/> Fail	<input type="checkbox"/> Screening not done	
Stereopsis	<input type="checkbox"/> Pass <input type="checkbox"/> Fail	Left ear	<input type="checkbox"/> Pass <input type="checkbox"/> Fail	<input type="checkbox"/> Referral made	
Color	<input type="checkbox"/> Pass <input type="checkbox"/> Fail	Child wears hearing aid?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Comments	
Child wears glasses?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Child under the care of a hearing specialist	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____	
Tested with glasses?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Referral made?	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____	
Referral made?	<input type="checkbox"/> Yes <input type="checkbox"/> No			_____	

## Speech/Language

Speech assessment completed  Yes  No

Child has no discernible speech problem  Yes  No

Speech evaluation recommended  Yes  No

Child has possible problem with \_\_\_\_\_

## Lead Poisoning

Date \_\_\_\_\_ Type  C  V Results \_\_\_\_\_ µg/dL

Date \_\_\_\_\_ Type  C  V Results \_\_\_\_\_ µg/dL

**Tuberculin Test**  
Date \_\_\_\_\_ Type \_\_\_\_\_ Results \_\_\_\_\_

## Health History (Serious or chronic illnesses/injuries/surgeries)

\_\_\_\_\_

## Physical Examination Date of most recent examination / /

Essentially normal  Abnormalities as follows

\_\_\_\_\_

Is this child able to participate fully in:

Classroom and academic activities  Yes  No      Physical education classes  Yes  No

Competition athletics  Yes  No      Contact and collision sports  Yes  No

If limitations are advised, please specify

\_\_\_\_\_

Does this child have any physical, developmental or behavioral issues that may affect his/her educational process?

\_\_\_\_\_

HealthCare Provider's signature		Print name		Phone ( )	
Address				Date / /	
City			State	ZIP	

# Ohio Department of Health • School and Adolescent Health

## Oral Assessment

Student's name	Date of birth / /
----------------	----------------------

The following services have been performed (please check all that apply)

<input type="checkbox"/> Examination	<input type="checkbox"/> Fluoride application	<input type="checkbox"/> Oral prophylaxis (cleaning)	<input type="checkbox"/> Prescription for fluoride supplement
<input type="checkbox"/> Orthodontic assessment	<input type="checkbox"/> Radiographs	<input type="checkbox"/> Dental sealant	<input type="checkbox"/> Treatment (restoration, pulp therapy)
<input type="checkbox"/> Other _____			

The following oral hygiene instruction was provided (please check all that apply)

<input type="checkbox"/> Toothbrushing	<input type="checkbox"/> Flossing	<input type="checkbox"/> Dietary counseling	<input type="checkbox"/> Use of fluoride mouthrinse
<input type="checkbox"/> Other _____			

The following statements are applicable (please check all that apply)

<input type="checkbox"/> All necessary preventive services have been performed. (Fluoride treatment, prophylaxis)
<input type="checkbox"/> No restorative services are required at this time.
<input type="checkbox"/> Further treatment is indicated.(See comments)
<input type="checkbox"/> Further appointments have been arranged. (Orthodontic, restorative)
<input type="checkbox"/> Routine recall visits recommended.

Comments

---



---



---



---

Dentist's signature	Print name	Phone (      )
Address		Date / /
City	State	ZIP