

To be Completed by Parent/Guardian

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"/> YES , my child receives regular medical/health care for the following conditions:			<input type="checkbox"/> NO 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.

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		

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