Ohio School Health History

To be used for Pre-and Elementary School

School _____

Enrolled _____

Child's Name	Gender	Age	Birthdate
	☐ Male ☐ Female		

Name of child's parent/legal guardian/s? _____

Parent/Guardian address _____

Home Phone number _____

Ethnicity

☐ Caucasian ☐ African American ☐ Hispanic ☐ Asian American ☐ Other

Social Service History

Mark the box if you have contact with any of the following agencies:

☐ Child/Protective Services If yes, Case worker's name _____

☐ Legal/Court System

☐ Family Counseling Services

☐ Mental Health Provider

☐ Other: _____

Mark the box if you or your child receive any of the following medical assistance:

☐ SSI, Disability ☐ Healthy Start ☐ Insurance (Blue Cross/Blue Shield, HMO)

☐ LEAP ☐ Medicaid/CHIP ☐ Other

Family History

Please list the first and last name of all the child's family members including parents and siblings.

Name	Birthdate	Gender	Health Concerns	Is the child in school?	If so, where?

Perinatal History

Did the mother have any unusual physical or emotional illness during this pregnancy? ☐ Yes ☐ No

If yes, explain briefly _____

How old was the mother when the child was born? _____

What was the infant's birth weight? _____ lbs. _____ oz. ☐ Full term ☐ Early ☐ Late

Did the infant have any sickness or problems? ☐ Yes ☐ No

If yes, explain briefly _____

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/her siblings or playmates?

☐ About the same ☐ Delayed ☐Advanced

Allergies

Please list and describe allergies and reactions

Medications/Drugs
Foods/plants/animals/other
Recommended treatment if allergy is severe

Injuries, Illnesses and 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/ or frequently.

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.

- ☐ Abnormal spinal curvature (Scoliosis)
- ☐ Allergies/hayfever
- ☐ Anemia
- ☐ Anaphylactic reaction
- ☐ Asthma or wheezing
- ☐ Attention deficit disorder (ADD)
- ☐ Behavior problem
- ☐ Birth or congenital malformation
- ☐ Cancer type_____
- ☐ Chickenpox when _____
- ☐ Chronic Diarrhea or constipation
- ☐ Chronic ear infections
- ☐ Concern about relation with siblings or friends
- ☐ Cystic Fibrosis
- ☐ Diabetes
- ☐ Eczema/Chronic skin conditions
- ☐ Emotional Problems
- ☐ Eye problems, poor vision
- ☐ Frequent headaches
- ☐ Frequent sore throats
- ☐ Heart disease type_____
- ☐ Hemophilia
- ☐ Hepatitis
- ☐ HIV positive
- ☐ Hyperactivity
- ☐ Juvenile Arthritis
- ☐ Kidney disease type_____
- ☐ Measles (10 day)
- ☐ Meningitis or Encephalitis
- ☐ Mumps
- ☐ Mutism
- ☐ Near-drowning/Near-suffocation
- ☐ Nervous twitches or tics
- ☐ Poisoning
- ☐ Rheumatic fever
- ☐ Seizure disorder/Epilepsy
- ☐ Sickle Cell Disease
- ☐ Speech difficulties
- ☐ Stool soiling
- ☐ Toothaches or dental problems
- ☐ Tourette's Syndrome
- ☐ Urinary tract infections
- ☐ 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 in 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?

_____

_____

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.

_____

_____

Is the student enrolled in a special education course? ☐ Yes ☐ No

If yes, please list _____

_____ _____

Parent/Guardian Signature Date

Mayfield City Schools Medication Policy Highlights

Mayfield City Schools discourages medication administration at school. If it is considered necessary by your physician, a form with parent consent and physician's prescription must be on file in the school clinic before the medication can be administered. This policy also includes "over-the-counter" medications. Required forms for medication administration at school are available in the school office. There are forms required for students to carry emergency rescue medications. Questions about medication administration at school should be directed to the school nurse. The complete policy is in the Student and Parent Handbook.

Immunization Record

It is required by the State of Ohio Revised Code for schools to have an immunization record on file before the student can enter/attend school. Please provide the school with a copy from your child's health care provider. You will be notified by the clinic staff if additional information or immunizations are required.

Vision:

♣ Has this child had any vision problems? NO o YES o

♣ Does your child wear glasses? NO o YES o contacts? NO o YES o

♣ Has your child been seen by an eye specialist? NO o YES o

Eye specialist name: _____ Date of exam: ___/___/___

Hearing:

♣ Has your child experienced frequent ear infections? NO o YES o

♣ Does this child have any problem with hearing? NO o YES o

If yes, please explain _____

PLEASE refer to your school's Parent and Student Handbook for the detailed Health Policies and Procedures.

READ AND INITIAL THE FOLLOWING:

♣ _____I have read and understand the medication policy.

♣ _____I have read and understand that I am responsible for providing immunization information to Mayfield City Schools.

♣ _____I understand any changes in the health status of my child should be reported to the school nurse.

♣ _____I understand my child's medical information will be communicated to appropriate staff as determined necessary by the school nurse for the safety of my child.

Completed by: _____ Date: ___/___/___

(Signature) Relationship to Child: _____