

**HEALTH HISTORY FORM**  
**Ohio Department of Health**  
**School and Adolescent Health History**

Student's Name \_\_\_\_\_

Male

Female

Date of Birth: Month \_\_\_\_\_ Day \_\_\_\_\_ Year \_\_\_\_\_

**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?      Yes      No

Was infant born full term?      Yes      No      Did the infant have any sickness or problems?      Yes      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?

About the same

Delayed

Advanced

**Student Health Conditions**

No medical conditions

Yes, my child receives regular medical/health care for the following conditions:

Allergies

Diabetes

Seizure disorder

Asthma

Depression

Sickle cell anemia

ADD/ADHD

Ear problem/hearing difficulty

Skin Conditions

Autism

Emotional concerns

Speech problems

Behavior concerns

Headaches

Traumatic brain injury

Birth/congenital malformations

Heart problems

Vision (glasses, contacts)

Bone/muscle/joint problems

Hemophilia

Other \_\_\_\_\_

Blood problems

Juvenile arthritis

Other \_\_\_\_\_

Bowel/bladder problems

Lead poisoning

Other \_\_\_\_\_

Cancer

Migraines

Other \_\_\_\_\_

Cystic fibrosis

Neuromuscular disorder

Other \_\_\_\_\_

**Please explain any conditions above or any reason for hospitalization.**

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**Please indicate any allergies your child may have.**

Allergy type	Reaction	School restrictions or recommended actions
Bee/Insect		
Food		
Medication		
Other		

**Please list any prescription and over the counter medications 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.

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

Yes          No          If yes, please explain.

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**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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\_\_\_\_\_  
Printed Name of person completing form

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Relationship to student

\_\_\_\_\_  
Date