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Ohio Department of Health
School and Adolescent Heath 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.

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.

Does the student require any special procedures and/or treatment 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.

Printed Name of person completing form | Relationship to student | Date