Dublin City School District

Student Health History Form

- Form must be completed and signed by parent at registration before student starts school.
- Form must be filed in student's health record at the assigned school building.

DEMOGRAPHIC DATA

Student's name: _____ Date enrolled: _____

Grade: _____ Birthdate: _____ Male: ☐ Female: ☐

Student's address: _____
street city state zip

Parent/Guardian names - Mother: _____ Father: _____

Phone: _____ Sibling names/ages: _____

MEDICATIONS

List medications given daily: _____ _____ _____ _____

Reason given: _____ _____ _____ _____

ALLERGIES

☐ Yes, indicate type of known allergies below ☐ None known

	Name/Type	Reaction	Treatment
Animals	_____	_____	_____
Drugs	_____	_____	_____
Environmental	_____	_____	_____
Foods	_____	_____	_____
Bees/wasps	_____	_____	_____

HEALTH HISTORY (Please check all conditions your child has or has had, and explain below)

- ☐ ADD/ADHD
- ☐ Arthritis/joints
- ☐ Asthma
- ☐ Birth defects
- ☐ Blood disorder
- ☐ Bowel problems
- ☐ Cancer
- ☐ Developmental delays
- ☐ Diabetes
- ☐ Hearing problems
- ☐ Heart problems
- ☐ Hepatitis
- ☐ Hospitalizations
- ☐ Learning problems
- ☐ Menstrual problems
- ☐ Mental health issues
- ☐ Migraines
- ☐ Physical limitations
- ☐ Relationship issues
- ☐ Seizures, tics or tremors
- ☐ Serious illnesses
- ☐ Skin problems
- ☐ Stomach problems
- ☐ Surgeries
- ☐ Urinary problems
- ☐ Visual problems
- ☐ Other

Health concern checked above	Age of child @ diagnosis	Hospitalization date(s)	Any long term problems
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Student Health History Form (cont.)

Student's name: _____

PREGNANCY AND BIRTH HISTORY

Mom's age at time of pregnancy: _____

Any problems with mom or baby during the pregnancy? _____

Length of pregnancy: ____ weeks Length of labor: ____ hours Baby's birth weight: ____ lbs. ____ oz.

Any complications with delivery or baby after birth? _____

SPEECH AND LANGUAGE DEVELOPMENT

Are you concerned your child may have or has had a problem with speech or language development? _____

What are your concerns? _____

Any past speech therapy? _____ Where and when? _____

DIETARY

Do you have any concerns about your child's nutrition? _____

Any weight concerns? _____ Does your child eat breakfast? ☐ lunch? ☐ dinner? ☐

Does your child have any dietary restrictions? _____

OTHER CONCERNS

Please share other information or concerns about your child's emotional, physical, or developmental growth.

_____

_____

Please share any family circumstances or behavioral concerns you have about your child.

_____

_____

Is your child on an IEP or 504 Plan ☐ yes ☐ no

Please contact the Ohio Benefits website @ www.ohiomh.com or call 800-324-8680 to see if you may be eligible for individual, family, or student Medicaid or Medicare insurance.

Check if you would like a conference with the school nurse. ☐

Parent/Guardian
Printed name: _____ Relationship: _____

Parent/Guardian
Signature: _____ Date: _____