



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)

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

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: _____