Student Health History

CHILD'S LAST NAME | FIRST | MIDDLE | DATE OF BIRTH

Ohio state law allows a 15 school day period for you to provide a record of your child's immunizations. After the 15 day period, your child will be excluded, until this is provided. Immunization law requires: 5 DPT, 4 Polio, 2 MMR (measles, mumps, rubella), 3 Hepatitis B, and 2 Varicella (chickenpox). Students are also required in grade 7 to receive a Tdap vaccine. Tuberculin testing is required for those students entering from another country.

* Information provided on this form will be shared with school personnel who interact with your child to ensure his/her safety at school unless you note otherwise.

I. Health Conditions – Please check any that apply:

_____ Abnormal Spinal Curve (Scoliosis, etc)
_____ Activity Restrictions (describe below)
_____ ADD / ADHD
_____ Allergies (list below)
_____ Anemia
_____ Arthritis
_____ Asthma, Inhaler Needed? _____
_____ Birth or Congenital Malformation
_____ Bleeding / Blood Disorders
_____ Cancer, Type ________________
_____ Chickenpox
_____ Cystic Fibrosis
_____ Diabetes
_____ Chronic Diarrhea or Constipation
_____ Eczema
_____ Emotional Concerns
_____ Heart Disease
_____ Kidney Disease
_____ Measles / Mumps / Rubella
_____ Meningitis / Encephalitis
_____ Rheumatic Fever
_____ Seizures, Type ________
_____ Sickle Cell Disease
_____ Skin Rashes (frequent)
_____ Tics/Nervous Twitches
_____ Urinary Tract Infections
_____ Hepatitis, Type _______
_____ Other (list below)

Please comment, as you feel necessary, on any of the above and list any specific allergies:

____

____

II. Vision and Hearing

Frequent ear infections? _______ Which ear? _______ Does your child have a reduction in hearing? _______ Explain ______________________________
P.E. Tubes? _______ In place now? _______ Hearing Aids? ____________________

Vision problem? _______ Type _________________ Wears glasses? _____________
Amblyopia or lazy eye? _______ Which eye? _______ Last Exam _______________
Color Blind? _______ Do you suspect a vision or hearing problem? _______________

III. Medications

What medications are given daily? ______________________________
Allergy to drugs? (please specify, e.g., penicillin, aspirin, etc.) ____________________
List any emergency meds your child requires (i.e. inhaler, epi-pen) ________________

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IV. Serious Injuries/Impairments/Hospitalizations

List ____

____

________________________________ ______________

Parent Signature | Date | Revised 1-13