Ohio School Health History Form

Parent Form

School: ___________________________________

Enrolled: ____________ *Grade*: __________

D.O.B: _______/________/_______

____

Student's Last Name First Name Middle Name

____

Student's Address

____

Parent/Legal Guardian Address if different from above

____

Home Phone Work Phone Cell Phone

Form Completed by: __________________________________ Relationship to Child: __________________________

Family History: Please list names of all Child's family members, including parents and siblings

Name	Birthdate	Health Concerns? YES or NO	Is the child in school this year? YES or NO	If so, where?
1.				
2.				
3.				
4.				
5.				
6.				

Allergies

Please list and describe allergies or reactions.

Medication/Drugs
Food/plants/animals/other
Recommended treatment if allergy is severe

Injuries, Illnesses and Hospitalizations

Please list any severe injuries, illnesses and hospitalizations including inpatient and outpatient surgical procedures

Injuries/Illness/Hospitalization	Age	If hospitalized, please explain

Medical Information

Please describe any medications that your child takes daily or frequently

Name of Medication	What is the medication for?	How often and what time(s) is medication taken?

Please add any comments or concerns you have about our child's health, development, behavior, family or home life that you would like us to be aware of.

____

____

____

Health Conditions

Please check any medical conditions that the child currently has or has had in the past.

___ Abnormal spinal curvature
___ Allergies/hay fever
___ Anemia
___ Anaphylactic reaction
___ Asthma or wheezing
___ Attention Deficit Disorder
___ Autism
___ Behavioral Problems
___ Birth or congenital malformation
___ Cancer
___ Chronic diarrhea or constipation
___ Chronic ear infection
___ Concern about relation with siblings or friends
___ Cystic Fibrosis
___ Diabetes
___ Eczema/Chronic skin conditions
___ Emotional problems
___ Eye problems, poor vision
___ Heart disease
___ Hemophilia
___ Hepatitis
___ HIV positive
___Hyperactivity
___ Kidney disease
___ Measles
___ Meningitis or Encephalitis
___ Mumps
___ Nervous twitches or tics
___ Poisoning
___ Rheumatic fever
___ Seizure disorder
___ Sickle Cell disease
___ Speech difficulties
___ Urinary infections
___ Other:

Ohio School Health History Form

Physical Assessment Form

School: ______________________________
Date Enrolled ___________ Grade ________

Student's Legal Last Name	First Name	Middle Name	

Date of Physical Examination: ______________________________ **Today's Date:** _________________________

Screening Data

Vision Date:	Hearing Date:
Distance Acuity Right ______ Left _____	Pure tone testing:
Muscle Balance Pass Fail Not done	Right ear Pass Fail Not done
Stereopsis Pass Fail Not done	Left ear Pass Fail Not done
Color Pass Fail Not done	Student wears hearing aid? Yes No
Student wears glasses? Yes No	Testing with hearing aid? Yes No
Tested with glasses? Yes No	Referral made? Yes No
Referral made? Yes No	Other test (specify)

Speech Assessment Date: _________________________

Student has no discernable speech problems

Student has possible problem with: (Circle all that apply) Articulation Rhythm Voice Language

Speech evaluation is recommended: Yes No

Objective Data

Height	Weight	BP
Laboratory Tests:		
☐ Hemoglobin/Hematocrit ☐ Urine Protein ☐ Urine Blood ☐ Urine Glucose ☐ Other: ____________		

Physical Exam:

☐ Physical Exam essentially was within normal limits
☐ Physical Exam is *not* within normal limits.
Explain:

____

____

Does this student have any physical, developmental, or behavioral problems? YES NO
If yes, please suggest special programs, placement or attention the school can provide.

____

Activities and Limitations

Can the student participate fully in the following activities?

Classroom academic activities	Yes	No
Physical education classes	Yes	No
Competitive athletics	Yes	No
Contact and collision sports	Yes	No

Medications: Is this student on any medications? Yes No
Explain: ____

Examiner's Signature: ________________________________ **Date Signed** _______________

____
Examiner's Printed Name

Address: ____**Phone #:** __________________

Immunizations

Please list the dates of the following immunizations (month/date/year)

DTaP/DT Tdap/Td						
Polio						
MMR						
Hepatitis B						
Varicella (chicken pox)						
Hepatitis A						
Hib						
Influenza (yearly)						

Tuberculin Test

Date:	Type:	Results:
Date:	Type:	Results:

Note: A copy of your child's immunizations record may be attached to this form.

Source of information: (check one) ______ Parent/Legal Guardian
______ Physician's Office
______ Local Health Department
______ Other (specify) ______________________________

____
Signature of person providing information

____
Date

Ohio School Health Oral Assessment Form

School: ______________________________ Date Enrolled: __________________ Grade: ______

____

Student's Legal Last Name First Name Middle Name

Student's address: _________________________________ Age: ____________

_________________________________ Date of Birth: ____ /____ /____

The following service have been performed (please check all that apply)

- ☐ Examination
- ☐ Oral prophylaxis (cleaning)
- ☐ Treatment (restoration, pulp therapy, extraction)
- ☐ Radiographs
- ☐ Dental Sealants
- ☐ Fluoride application
- ☐ Prescription for fluoride supplements
- ☐ Orthodontic assessment
- ☐ Other: ____

The following oral hygiene instruction was provided (please check all that apply)

- ☐ Toothbrushing
- ☐ Flossing
- ☐ Dietary Counseling
- ☐ Home/School use of fluoride mouth rinse
- ☐ Other: ____

The following statements are applicable (please check all that apply)

- ☐ All necessary preventative services have been performed (fluoride treatment, prophylaxis)
- ☐ No restorative services are required at this time.
- ☐ No further treatment is indicated (see comments)
- ☐ Further appointments have been arranged (ex. Orthodontics, restorative)
- ☐ Routine recall visits recommended

Comments:

Dentist's Signature: ____ Date: ______________

Dentist's Printed Name: ____

Address:

____

____

Phone: _______________________________