

Ohio Department of Health • School and Adolescent Health

Health History

Student's name	Sex <input type="checkbox"/> Male <input type="checkbox"/> Female	Date of birth / /
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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?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Was infant born full term? <input type="checkbox"/> Yes <input type="checkbox"/> No	Did the infant have any sickness or problems? <input type="checkbox"/> Yes <input type="checkbox"/> 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? <input type="checkbox"/> About the same <input type="checkbox"/> Delayed <input type="checkbox"/> Advanced	

Student Health Conditions

<input type="checkbox"/> YES , my child receives regular medical/health care for the following conditions:		<input type="checkbox"/> NO medical conditions
<input type="checkbox"/> Allergies	<input type="checkbox"/> Diabetes	<input type="checkbox"/> Seizure disorder
<input type="checkbox"/> Asthma	<input type="checkbox"/> Depression	<input type="checkbox"/> Sickle cell anemia
<input type="checkbox"/> ADD/ADHD	<input type="checkbox"/> Ear problem/hearing difficulty	<input type="checkbox"/> Skin conditions
<input type="checkbox"/> Autism	<input type="checkbox"/> Emotional concerns	<input type="checkbox"/> Speech problems
<input type="checkbox"/> Behavior concerns	<input type="checkbox"/> Headaches	<input type="checkbox"/> Traumatic brain injury
<input type="checkbox"/> Birth/congenital malformations	<input type="checkbox"/> Heart problems	<input type="checkbox"/> Vision problems (glasses, contacts)
<input type="checkbox"/> Bone/muscle/joint problems	<input type="checkbox"/> Hemophilia	<input type="checkbox"/> Other _____
<input type="checkbox"/> Blood problems	<input type="checkbox"/> Juvenile arthritis	<input type="checkbox"/> Other _____
<input type="checkbox"/> Bowel/bladder problems	<input type="checkbox"/> Lead poisoning	<input type="checkbox"/> Other _____
<input type="checkbox"/> Cancer	<input type="checkbox"/> Migraines	<input type="checkbox"/> Other _____
<input type="checkbox"/> Cystic fibrosis	<input type="checkbox"/> Neuromuscular disorder	<input type="checkbox"/> Other _____
Please explain any conditions above or any reasons for hospitalizations. _____		
Please indicate any allergies your child may have.		
Allergy type	Reaction	School restrictions or recommended actions
<input type="checkbox"/> Bee/Insect		
<input type="checkbox"/> Food		
<input type="checkbox"/> Medication		
<input type="checkbox"/> Other		

Health History continued

Please list any prescription and over the counter medication 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 treatments 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.

Form completed by	Relationship to student	Date / /
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Physical Examination

To be completed by Health Care Provider

Student's name		Sex <input type="checkbox"/> Male <input type="checkbox"/> Female	Date of birth / /
Height	Weight	BMI percentile	BP

Screening Tests

Vision	Hearing	Postural
Date performed / /	Date performed / /	Date performed / /
Distance Acuity <input type="checkbox"/> R <input type="checkbox"/> L Muscle Balance <input type="checkbox"/> Pass <input type="checkbox"/> Fail Stereopsis <input type="checkbox"/> Pass <input type="checkbox"/> Fail Color <input type="checkbox"/> Pass <input type="checkbox"/> Fail Child wears glasses? <input type="checkbox"/> Yes <input type="checkbox"/> No Tested with glasses? <input type="checkbox"/> Yes <input type="checkbox"/> No Referral made? <input type="checkbox"/> Yes <input type="checkbox"/> No	Pure Tone Right ear <input type="checkbox"/> Pass <input type="checkbox"/> Fail Left ear <input type="checkbox"/> Pass <input type="checkbox"/> Fail Child wears hearing aid? <input type="checkbox"/> Yes <input type="checkbox"/> No Child under the care of a hearing specialist <input type="checkbox"/> Yes <input type="checkbox"/> No Referral made? <input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> No abnormality noted <input type="checkbox"/> Screening not done <input type="checkbox"/> Referral made Comments _____ _____ _____

Speech/Language

Lead Poisoning

Speech assessment completed <input type="checkbox"/> Yes <input type="checkbox"/> No Child has no discernible speech problem <input type="checkbox"/> Yes <input type="checkbox"/> No Speech evaluation recommended <input type="checkbox"/> Yes <input type="checkbox"/> No Child has possible problem with _____	<table border="1" style="width:100%; border-collapse: collapse;"> <tr> <td><input type="checkbox"/> Date _____</td> <td>Type <input type="checkbox"/> C <input type="checkbox"/> V</td> <td>Results _____ µg/dL</td> </tr> <tr> <td><input type="checkbox"/> Date _____</td> <td>Type <input type="checkbox"/> C <input type="checkbox"/> V</td> <td>Results _____ µg/dL</td> </tr> </table> <p>Tuberculin Test Date _____ Type _____ Results _____</p>	<input type="checkbox"/> Date _____	Type <input type="checkbox"/> C <input type="checkbox"/> V	Results _____ µg/dL	<input type="checkbox"/> Date _____	Type <input type="checkbox"/> C <input type="checkbox"/> V	Results _____ µg/dL
<input type="checkbox"/> Date _____	Type <input type="checkbox"/> C <input type="checkbox"/> V	Results _____ µg/dL					
<input type="checkbox"/> Date _____	Type <input type="checkbox"/> C <input type="checkbox"/> V	Results _____ µg/dL					

Health History (Serious or chronic illnesses/injuries/surgeries)

Physical Examination Date of most recent examination / /

Essentially normal Abnormalities as follows

Is this child able to participate fully in:

Classroom and academic activities	<input type="checkbox"/> Yes <input type="checkbox"/> No	Physical education classes	<input type="checkbox"/> Yes <input type="checkbox"/> No
Competition athletics	<input type="checkbox"/> Yes <input type="checkbox"/> No	Contact and collision sports	<input type="checkbox"/> Yes <input type="checkbox"/> No

If limitations are advised, please specify

Does this child have any physical, developmental or behavioral issues that may affect his/her educational process?

HealthCare Provider's signature	Print name	Phone ()
Address		Date / /
City	State	ZIP

Ohio Department of Health • School and Adolescent Health
Immunization Report

Student's name	Sex <input type="checkbox"/> Male <input type="checkbox"/> Female	Date of birth / /
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Students are required to be immunized in accordance with Ohio law (Ohio Revised Code 3313.67/3313.671).
 A copy of the child's immunization record may be attached or dates may be entered below.
 Please note the month, day, and year for each immunization should be on record.

Vaccine	Record complete dates (month, day, year) of vaccine doses given				
Diphtheria, Tetanus, Pertussis (DTP)					
DTaP, Tdap					
DT, Td					
Polio					
Hepatitis B (HBV)					
Measles, Mumps, Rubella (MMR)					
Varicella (Chickenpox)					
Hepatitis A					
Meningococcal (MCV4, MPSV4)					
Pneumococcal (PCV)					
Measles (Rubeola) only					
Rubella only					
Mumps only					
Haemophilus influenza Type b (Hib)					
Influenza					
Other					

This information was provided by Health Care Provider Parent/Guardian Other _____

Signature	Print name	Date / /
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Authorization to Disclose Immunization Information

Name of Child _____ Date of Birth _____

I, _____, as the parent of guardian of the above named child, hereby authorize (Name of Provider[s])

to disclose the specific and individually identifiable immunization records of the above named child to (Name of School):

for the specific purpose of presenting written evidence, satisfactory to the person in charge of admission, that the above named child has been immunized by a method of immunization approved by the department of health as required by section 3313.671 of the Ohio Revised Code.

This authorization will expire upon the presentation of written evidence sufficient to comply with section 3313.671 of the Ohio Revised Code or for the period of time needed to fulfill its purpose. I also understand that I may revoke this authorization, in writing, at any time and that I may be asked to sign the Revocation Section on the back of this form. I further understand that any action taken by the above named Provider(s) or School in accordance to this authorization prior to it being revoked is legal and binding.

I understand that my information may not be protected from re-disclosure by the requester of the information unless otherwise provided for by state or federal law. Please note: medical records provided to schools that receive federal funding are protected by the Family Educational Rights and Privacy Act (FERPA).

I also understand that I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment, payment for services, or my eligibility for benefits; however, if a service is requested by a non-treatment provider (e.g., insurance company) for the sole purpose of creating health information (e.g., physical exam), service may be denied if authorization is not given.

I also understand that my refusal to sign this authorization may prevent the school from verifying that the above named child has been immunized. I further understand that if the school cannot verify and I cannot provide satisfactory written evidence that the above named child has been immunized, the child may be excluded from school pursuant to section 3313.671 of the Ohio Revised Code.

I further understand that I may request a copy of this signed authorization.

(Signature of Personal Representative) (Date) (Relationship / Authority)

NOTE: This Authorization was revoked on: _____
(Date) (Signature of Staff)