Ohio Department of Health • School and Adolescent Health

Health History

Student'a Name:_____ Sex: Male: ☐ Female ☐ Date of Birth: _____

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? ☐ Yes ☐ No

Was infant born full term? ☐ Yes ☐ No Did the infant have any sickness or problems? ☐ Yes ☐ 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?

☐ About the same ☐ Delayed ☐ Advanced

Student Health Conditions

☐ YES,my child receives regular medical/health care for the following conditions: ☐ NO medical conditions

❑ Allergies	❑ Diabetes	❑ Seizure disorder
❑ Asthma	❑ Depression	❑ Sickle cell anemia
❑ ADD/ADHD	❑ Ear problem/hearing difficulty	❑ Skin conditions
❑ Autism	❑ Emotional concerns	❑ Speech problems
❑ Behavior concerns	❑ Headaches	❑ Traumatic brain injury
❑ Birth/congenital malformations	❑ Heart problems	❑ Vision problems (glasses, contacts)
❑ Bone/muscle/joint problems	❑ Hemophilia	❑ Other
❑ Blood problems	❑ Juvenile arthritis	❑ Other
❑ Bowel/bladder problems	❑ Lead poisoning	❑ Other
❑ Cancer	❑ Migraines	❑ Other
❑ Cystic fibrosis	❑ Neuromuscular disorder	❑ 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
❑ Bee/Insect		
❑ Food		
❑ Medication		
❑ Other		