

Ohio School Health History

Date: _____ School: St. Anthony School Grade: _____

Child's Name	Gender	Birthdate	Age	Grade
Ethnicity <input type="checkbox"/> Caucasian <input type="checkbox"/> African American <input type="checkbox"/> Hispanic <input type="checkbox"/> Asian American <input type="checkbox"/> Other				
Who is the child's legal guardian?		Who does the child live with?		Child's address
Parent/Guardian		Parent/Guardian Address		Home phone number

Social Service History: Mark the box if you have contact with any of the following agencies:

- Child Protective Services Case worker's name: _____
 Legal/Court System
 Family Counseling Service Mental Health Provider
 Other: _____

Mark the box if you or your child receives any of the following medical assistance:

- Private Insurance Medicaid Healthy Start Other: _____

Family History

Please list first and last name of all the child's family members including parents and siblings.

Name	Birthdate	Gender	Health Concerns	Is the child in school? If so, where?
1.				
2.				
3.				
4.				
5.				

Perinatal History

Did the mother have any unusual physical or emotional illness during this pregnancy? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, explain briefly:
Age of mother at time of birth: _____ Was the infant: <input type="checkbox"/> Full term <input type="checkbox"/> Early <input type="checkbox"/> Late Birth weight: ___ lbs ___ Oz
Did the infant have any sickness or problems? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, explain briefly:

Developmental History

Please give approximate age at which child: Walked alone: _____ Spoke in sentences: _____ Toilet Trained: _____ Dressed Self: _____ Development compared to siblings or playmates: <input type="checkbox"/> About the same <input type="checkbox"/> Advanced <input type="checkbox"/> Delayed _____

Health Conditions: Please check or circle any medical conditions that the child has experienced.

- | | |
|--------------------------------------------------------------|--------------------------------------------------------------------|
| <input type="checkbox"/> No medical conditions | <input type="checkbox"/> Ear problems/hearing loss/aids |
| <input type="checkbox"/> Allergies | <input type="checkbox"/> Emotional problems |
| <input type="checkbox"/> Anaphylactic reaction | <input type="checkbox"/> Frequent ear infections/tubes |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Frequent upper respiratory infections |
| <input type="checkbox"/> Arthritis: Type: _____ | <input type="checkbox"/> Hayfever |
| <input type="checkbox"/> Asthma: Triggers: _____ | <input type="checkbox"/> Headaches: Type: _____ |
| <input type="checkbox"/> ADD/ADHD | <input type="checkbox"/> Heart problems |
| <input type="checkbox"/> Autism | <input type="checkbox"/> Near drowning or suffocation: Date: _____ |
| <input type="checkbox"/> Blood disorder | <input type="checkbox"/> Nervous twitches or tics |
| <input type="checkbox"/> Bone/muscle/joint problems | <input type="checkbox"/> Neuromuscular disorder |
| <input type="checkbox"/> Bowel problems | <input type="checkbox"/> Poisoning: Type: _____ |
| <input type="checkbox"/> Cancer: Type: _____ | <input type="checkbox"/> Skin conditions: Type: _____ |
| <input type="checkbox"/> Communicable disease/Date | <input type="checkbox"/> Seizure disorder: Type: _____ |
| <input type="checkbox"/> Chickenpox | <input type="checkbox"/> Speech problems: _____ Therapy: _____ |
| <input type="checkbox"/> Hepatitis: Type: _____ | <input type="checkbox"/> Spinal curvature: Type: _____ |
| <input type="checkbox"/> HIV | <input type="checkbox"/> Traumatic brain injury |
| <input type="checkbox"/> Meningitis: Type: _____ | <input type="checkbox"/> Urinary tract problems |
| <input type="checkbox"/> Other: _____ | <input type="checkbox"/> Vision problems: _____ |
| <input type="checkbox"/> Congenital/hereditary abnormalities | <input type="checkbox"/> glasses/contacts Last exam: _____ |
| <input type="checkbox"/> Dental problems. Last exam: _____ | <input type="checkbox"/> Wetting during the day or night |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Other: _____ |

Please explain any conditions above: _____

Injuries, Illnesses, and Hospitalizations

Injuries/Illness/Hospitalization	Age	If hospitalized, please explain

Has this child ever been in the emergency room or been hospitalized for a **head** injury?
 no yes Explain: _____

Has this child ever lost consciousness as a result of a fall, car accident or being hit in the head?
 no yes Explain: _____

Allergies

Allergy type	Reaction	Treatment
<input type="checkbox"/> Bee/insect		
<input type="checkbox"/> Food		
<input type="checkbox"/> Medication		
<input type="checkbox"/> Other		

Medication History: Prescription and over the counter medication taken regularly or frequently.

Medication and dose	Time/frequency	Reason

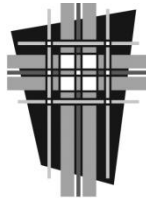
Behavioral History

The child is usually: <input type="checkbox"/> Very active <input type="checkbox"/> Normally active <input type="checkbox"/> Rather inactive <input type="checkbox"/> Outgoing <input type="checkbox"/> Shy
Has your child been violent or acted out in the following manner towards adults or children? <input type="checkbox"/> Hitting <input type="checkbox"/> Kicking <input type="checkbox"/> Biting <input type="checkbox"/> Fighting <input type="checkbox"/> Scratching
Do you have any concerns about how your child gets along with other children? <input type="checkbox"/> No <input type="checkbox"/> Yes. Explain
Does your child have any fears:
Sleep habits: # hours/night <input type="checkbox"/> snores <input type="checkbox"/> sleep walker <input type="checkbox"/> bedwetting <input type="checkbox"/> difficulties: Explain

Do you have other information or concerns about this child’s emotional health, growth and development, behavior or family circumstances that you feel the school nurse should know?

Form completed by:	Relationship to child:	Date:
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Please return to



ST. ANTHONY
- SCHOOL -

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