Ohio School Health History

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

Child's Name	Gender	Birthdate	Age	Grade

Ethnicity
□ Caucasian □ African American □ Hispanic □ Asian American □ 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? □ Yes □ No If yes, explain briefly:

Age of mother at time of birth: Was the infant: □ Full term □ Early □ Late Birth weight: ____lbs_____Oz

Did the infant have any sickness or problems? □ Yes □ 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: □ About the same □ Advanced □ Delayed _____

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

- **No medical conditions**
- Allergies
  - Anaphylactic reaction
- Anemia
- Arthritis: Type: _____
- Asthma: Triggers: _____
- ADD/ADHD
- Autism
- Blood disorder
- Bone/muscle/joint problems
- Bowel problems
- Cancer: Type: _____
- Communicable disease/Date
  - Chickenpox
  - Hepatitis: Type:
  - HIV
  - Meningitis: Type:
  - Other: _____
- Congenital/hereditary abnormalities
- Dental problems. Last exam: _____
- Diabetes
- Ear problems/hearing loss/aids
- Emotional problems
- Frequent ear infections/tubes
- Frequent upper respiratory infections
- Hayfever
- Headaches: Type: _____
- Heart problems
- Near drowning or suffocation: Date:
- Nervous twitches or tics
- Neuromuscular disorder
- Poisoning: Type: _____
- Skin conditions: Type: _____
- Seizure disorder: Type: _____
- Speech problems: _____ Therapy: _____
- Spinal curvature: Type: _____
- Traumatic brain injury
- Urinary tract problems
- Vision problems: _____
  - glasses/contacts Last exam: _____
- Wetting during the day or night
- 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
□ Bee/insect		
□ Food		
□ Medication		
□ 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: ☐ Very active ☐ Normally active ☐ Rather inactive ☐ Outgoing ☐ Shy
Has your child been violent or acted out in the following manner towards adults or children? ☐ Hitting ☐ Kicking ☐ Biting ☐ Fighting ☐ Scratching
Do you have any concerns about how your child gets along with other children? ☐ No ☐ Yes. Explain
Does your child have any fears:
Sleep habits: # hours/night ☐ snores ☐ sleep walker ☐ bedwetting ☐ 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:

Please return to

ST. ANTHONY
SCHOOL

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