Wadsworth City Schools

OHIO SCHOOL HEALTH HISTORY

Enrolled: _____
Withdrawn: _____
School: _____

Parent or Guardian: Complete all, except the physician's box on the reverse side, before physical examination.

Child's Full Name: _____
Last *First* *Middle*

☐ Male ☐ Female Birthdate: _____
Month *Day* *Year*

Child's Address: _____

Father's Name: _____

His Address (if different from child's): _____

His Work Phone: _____ His Home Phone: _____

Mother's Name: _____

Her Address (if different from child's): _____

Her Work Phone: _____ Her Home Phone: _____

With whom does child live? _____
Name *Relationship*

Please list this child's brothers and sisters:

FAMILY HISTORY

Name	Birth Year	Sex	Name	Birth Year	Sex
1.			4.		
2.			5.		
3.			6.		

HEALTH CONDITIONS (Please check any that this child has had):

☐ Abnormal spinal curvature (scoliosis, etc.)
☐ Allergies or hay fever
☐ Anemia
☐ Arthritis
☐ Asthma or wheezing
☐ Bedwetting at night
☐ Behavior problem
☐ Birth or congenital malformation
☐ Cancer, type: _____
☐ Chicken pox, date: _____
☐ Chronic diarrhea or constipation
☐ Concern about relationship with siblings or friends
☐ Cystic fibrosis
☐ Diabetes
☐ Eczema
☐ Emotional problems
☐ Eye problems, poor vision
☐ Frequent headaches
☐ Frequent skin infections
☐ Frequent sore throat infections
☐ Heart disease, type: _____
☐ Hepatitis
☐ Kidney disease, type: _____
☐ Measles ("old fashioned" or "ten-day")
☐ Meningitis or encephalitis
☐ Multiple ear infections (3 or more)
☐ Mumps
☐ Near-drowning or near-suffocation
☐ Nervous twitches or tics
☐ Poisoning
☐ Hearing problems, type: _____
☐ Pregnancy
☐ Rheumatic fever
☐ Seizures or epilepsy
☐ Sickle cell disease
☐ Stool soiling
☐ Substance abuse (alcohol, drugs)
☐ Suicide attempt
☐ Toothaches or dental infections
☐ Urinary tract infection
☐ Wetting during day

ALLERGIES (Please list any allergies and describe reactions): _____

_____

_____

Recommended treatment for an allergic reaction: _____

_____

INJURIES AND ILLNESSES (Please list any severe injuries or illnesses):

Injuries/Illnesses	Age of Child	If Hospitalized (Check)
_____	_____	☐
_____	_____	☐

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ADDITIONAL INFORMATION:

What medications are given daily? _____

What medications are given frequently, but not daily? _____

This child is usually: ☐ Very active ☐ Normally active ☐ Rather inactive

Do you have any concern about how your child gets along with other children? _____

_____

Do you have other comments or concerns about this child's health, development, behavior, family or home life of which you would like the school to be aware? If yes, explain briefly: _____

_____

_____

_____

Completed by: _____

Relationship to child: _____

TO BE COMPLETED BY PHYSICIAN:*

PHYSICAL EXAMINATION - Date examined: _____ ☐ Essentially normal Abnormalities as follows:

_____

_____

_____

_____

☐ Male ☐ Female Age: _____ Date: _____

OBJECTIVE DATA:

Height: _____ (%) Weight: _____ (%) B.P. _____ / _____

PLEASE CIRCLE ANY IMMUNIZATION RECEIVED AT THIS APPOINTMENT:

DTap	DPT	Hepatitis B
DT	Td	Varicella
Polio	MMR	HIB

Other: _____

Preschool Only: Hematocrit _____ (Date) OR ☐ I do not believe this is necessary at this time.

Preschool Only: Lead Poisoning Screening _____ (Date)

Please print or stamp:

Physician's Name: _____ Physician's Signature: _____

Address: _____

Phone: _____ Date Signed: _____

* Prior to the first day of November of the school year in which a pupil is **enrolled for the first time in either kindergarten or first grade**, this section must be completed.

Preschool: This section to be completed prior to date of admission or not later than 30 days after date of admission, and every 13 months from the date of examination thereafter. For children 3 years old or older at time of admission, the examination shall occur within 12 months prior to date of admission.