## Ohio Department of Health • School and Adolescent Health Health History

Student's name	Sex		Date of birth		
	🗌 Male	□ Female	/	/	

## **Family Health History** Please list allergies, heart problems, diabetes, cancer or other serious health conditions.

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	Did the infant have any sickness or problems?	□ Yes	🗆 No		
pare to other children, such as	his or her brothers/sisters or playmates?				
Delayed	□ Advanced				
	Yes No	Yes       No       Did the infant have any sickness or problems?         pare to other children, such as his or her brothers/sisters or playmates?	Yes       No       Did the infant have any sickness or problems?       Yes         pare to other children, such as his or her brothers/sisters or playmates?		

#### **Student Health Conditions**

<b>YES</b> , my child receives	regular medica	l/health care for the following condition	s: <b>NO</b> medical conditions
□ Allergies		Diabetes	□ Seizure disorder
🗆 Asthma			□ Sickle cell anemia
		$\Box$ Ear problem/hearing difficulty	□ Skin conditions
🗆 Autism		Emotional concerns	□ Speech problems
□ Behavior concerns		□ Headaches	Traumatic brain injury
Birth/congenital malfo	rmations	□ Heart problems	$\Box$ Vision problems (glasses, contacts)
Bone/muscle/joint prol	blems	🗌 Hemophilia	Other
□ Blood problems		□ Juvenile arthritis	Other
Bowel/bladder problen	ns	Lead poisoning	Other
□ Cancer		□ Migraines	□ Other
Cystic fibrosis		Neuromuscular disorder	□ Other
Please explain any conditions abov	e or any reasons fo	r hospitalizations.	
Please indicate any allergies your c	-		
Allergy type	Reaction		School restrictions or recommended actions
Bee/Insect			
Food			
□ Medication			
□ 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, me	odifications, 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 deve	lopment that you think would b	e heipful for the school to know.			
L					
Form completed by	Relationship to student		Date		
				/	/

# Ohio Department of Health • School and Adolescent Health Physical Examination

Image:       Image:       /         Itegit       Weight       BMI percentile       97         Screening Tests       Postural       Date performed       /         Date performed       /       /       /       /         Distance Acuity       R       L       Pure Tone       Pass       Fail       Date performed         Color       Pass       Fail       Reternal made       Condition of the care of marking specialist       Pvs       Fail       Condition of the care of marking specialist       Pvs       No         Child ward plass?       Pvs       No       Reternal made       Condition of the care of marking specialist       Pvs       No       Reternal made       Condition of the care of marking specialist       Pvs       No       Reternal made       Condition of the care of marking specialist       Pvs       No       Reternal made       Pvs       No       Reternal made       Pvs       No       Reternal made       Pvs       No       Date       Type       Conditions       Pvs       Pvs       No       Date       Type       Results       µg/dt       No       Date       Type       Results       Pvs       No       Date       Type       No       No       No       No       No       No	Student's name						Sex				Date of birth		
Screening Tests       Hearing       Postural         Date performed       /       /       //         Dist performed       /       /       //         Distance Aculy       R       L       Right ear       Pass       Fail       Screening not done         Stereopsis       Pass       Fail       Left ear       Pass       Fail       Comments       Comments         Child waars plassed?       Pyes       No       Child waars plassicialit       Yes       No         Color       Pass       Fail       Child waars plassicialit       Yes       No       Comments         Child waars plassed?       Pyes       No       Comments       Comments       Comments         Speech Assessment completed       No       No       Date       Type       C       V       Results       µg/dL         Speech assessment completed       Yes       No       Date       Type       Results       µg/dL         Child has possible problem with       Immescurinitarions       /       Immentins								Male	🗆 Fe	emale	/		/
Vision     Hearing     Postural       Date performed     Date performed     Date performed     Date performed       / /     Pure Tone     //     //     Part Part       Mucle Balance     Parts     Fail     Part     Part       Stereopsis     Parts     Fail     Part     Part     Referral made       Color     Parts     Fail     Child wares hearing aid?     Yes     No       Color     Parts     Fail     Child wares hearing aid?     Yes     No       Color     Parts     Fail     Child wares hearing aid?     Yes     No       Color     Parts     Fail     Child wares hearing aid?     Yes     No       Color     Parts     No     Color     Referral made     Comments       Child wares glasses?     Yes     No     Referral made?     Comments       Speech.Alanguage     Ecad Poisoning       Speech asside problem     Yes     No       Speech valuation recommended     Yes     No       Child has no discemible speech problem     Yes     No       Tuberculin Test     Date     Type     Results       Part     No     Tuberculin Test     Date       Date     partopartition atheatics     Yes     No	Height		Weight		E	3MI percent	ile			BP			
Vision     Hearing     Postural       Date performed     Date performed     Date performed     Date performed       / /     Pure Tone     //     //     Part Part       Mucle Balance     Parts     Fail     Part     Part       Stereopsis     Parts     Fail     Part     Part     Referral made       Color     Parts     Fail     Child wares hearing aid?     Yes     No       Color     Parts     Fail     Child wares hearing aid?     Yes     No       Color     Parts     Fail     Child wares hearing aid?     Yes     No       Color     Parts     Fail     Child wares hearing aid?     Yes     No       Color     Parts     No     Color     Referral made     Comments       Child wares glasses?     Yes     No     Referral made?     Comments       Speech.Alanguage     Ecad Poisoning       Speech asside problem     Yes     No       Speech valuation recommended     Yes     No       Child has no discemible speech problem     Yes     No       Tuberculin Test     Date     Type     Results       Part     No     Tuberculin Test     Date       Date     partopartition atheatics     Yes     No													
Vision     Hearing     Postural       Date performed     Date performed     Date performed     Date performed       / /     Pure Tone     //     //     Part Part       Mucle Balance     Parts     Fail     Part     Part       Stereopsis     Parts     Fail     Part     Part     Referral made       Color     Parts     Fail     Child wares hearing aid?     Yes     No       Color     Parts     Fail     Child wares hearing aid?     Yes     No       Color     Parts     Fail     Child wares hearing aid?     Yes     No       Color     Parts     Fail     Child wares hearing aid?     Yes     No       Color     Parts     No     Color     Referral made     Comments       Child wares glasses?     Yes     No     Referral made?     Comments       Speech.Alanguage     Ecad Poisoning       Speech asside problem     Yes     No       Speech valuation recommended     Yes     No       Child has no discemible speech problem     Yes     No       Tuberculin Test     Date     Type     Results       Part     No     Tuberculin Test     Date       Date     partopartition atheatics     Yes     No	Screening Tests												
/       /       /       /       /         Distance Acuity       R       L       Pure Tone       Bight ear       Pass       Fail       Screening not done         Muscle Balance       Pass       Fail       Effet ear       Pass       Fail       Child wears hearing and // LY es       No         Color       Pass       Fail       Child wears hearing and // LY es       No       Comments       Child wears hearing specialist       Ves       No         Color       Pass       No       Referral made?       Ves       No       Comments       Child wears hearing specialist       Ves       No         Speech/Language       Lead Poisoning       Eader       Type       C       V       Results       µg/dt         Speech completed       Yes       No       Date       Type       C       V       Results       µg/dt         Speech evaluation recommended       Yes       No       Date       Type       Results       µg/dt         Speech evaluation recommended       Yes       No       Date       Type       Results       µg/dt         Speech evaluation recommended       Yes       No       Correction results       No       Tubercuitin Test       Date       Type       <				Hearing					Post	ural			
Distance Acuity       R       L       Pure Tone       Nuscle Balance       Pass       Fail       Representation         Stereopsis       Pass       Fail       Lett ear       Pass       Fail       Child wears bearing aid?       Yes       No         Child wears glasse?       Yes       No       Child wears bearing aid?       Yes       No       Referral made         Speech/Language       Lead Poisoning       Speech systemible speech problem       Yes       No       Referral made?       Yes       No         Speech/Language       Lead Poisoning       Speech valuation recommended       Yes       No       Date       Type       C       V Results       µg/dL         Child under the care       of a hearing specialist       Date       Type       C C       V Results       µg/dL         Speech valuation recommended       Yes       No       Date       Type       Results       µg/dL         Haith History (Serious or chronic illnesses/injuries/surgerise)	Date performed			Date performed					Date p	erformed			
Muscle Balance       Pass       Fail       Right ear       Pass       Fail       Screening not done         Stereopsis       Pass       Fail       Child wears plasses?       Yes       No       Child under the care       Comments         Child wears plasses?       Yes       No       Child under the care       Comments       Comments         Speech/Language       Lead Poisoning       Speech/Language       Comments       Muscle Balance       Type       C       V Results       µg/dt         Speech/Language       Lead Poisoning       Speech/Language       Speech/Language       Speech/Language       Muscle Balance       Type       C       V Results       µg/dt         Speech/Language       Lead Poisoning       Speech/Language       Tuberculin Test       µg/dt       Tuberculin Test       µg/dt         Speech/Language       Ves       No       Date       Type       Results       Mug/dt         Speech/Language       Ves       No       Date       Type       Results       µg/dt         Speech/Language       Ves       No       Date       Type       Results       µg/dt         Speech/Language       Seconary of most recent examination       /       /       Seconary of most recent examination       / </td <td>/</td> <td>/</td> <td></td> <td>/</td> <td>/</td> <td></td> <td></td> <td></td> <td></td> <td></td> <td>/</td> <td>/</td> <td></td>	/	/		/	/						/	/	
Muscle Balance       Pass       Fail       Hight ear       Pass       Fail       Child vears plass of Fail       Comments         Color       Pass       Fail       Child vears plasses?       Yes       No       Comments         Child vears plasses?       Yes       No       Child vears plasses?       Yes       No         Speech/Language       Lead Poisoning         Speech/Language       Lead Poisoning         Speech assessment completed       Yes       No       Date       Type       C       V       Results       µg/dL         Speech assessment completed       Yes       No       Date       Type       C       V       Results       µg/dL         Speech valuation recommended       Yes       No       Date       Type       Results       µg/dL         Child has no discemible speech problem       Yes       No       Date       Type       Results       µg/dL         Tuberculin Test       Date       Type       Results       µg/dL         Tuberculin Test       Date       Type       Results       µg/dL         Commandia academic activities       Second       Yes       No       No         Physical Examination       Date       Yes <t< td=""><td>Distance Acuity</td><td>🗆 r 🛛</td><td>⊐ı</td><td>Pure Tone</td><td></td><td></td><td></td><td></td><td></td><td>o abnor</td><td>mality noted</td><td></td><td></td></t<>	Distance Acuity	🗆 r 🛛	⊐ı	Pure Tone						o abnor	mality noted		
Stereopsis Pass Fail Left ear Pass Fail Celeral made   Color Pass Fail Child wears hearing aid? Yes No   Child uwears hearing aid? Yes No Celeral made Comments   Tested with glasses? Yes No Referral made? Yes No   Speech/Language Lead Poisoning   Speech/Language Lead Poisoning   Speech collation recommended Yes No   Child has no sicenible speech problem Yes No   Tuberculin Test Tuberculin Test   Date Type Results   Physical Examination Date of most recent examination   I /   Essentially normal Abnormalities as follows   Statis child able to participate fully in:   Classroom and academic activities Yes   No Contact and collision sports   Yes No   Classroom and academic activities   Yes No   Classroom and academic activities   Yes No   Classroom and academic activities   Yes No   Contact and collision sports   Yes No   Test this child have any physical, developmental or behavioral issues that may af		Pass [	☐ Fail	Right ear	Pass	🗌 Fail							
Color       Pass       Fail       Child wears hearing aid?       Ves       No         Child under the care of a hearing specialist.       Ves       No       Child under the care of a hearing specialist.       Ves       No         Referral made?       Ves       No       Referral made?       Ves       No         Speech/Language       Lead Polsoning         Speech subscription       Ves       No         Speech values on poleted       Ves       No         Child has no discernible speech problem       Ves       No         Speech values on recommended       Ves       No         Child has no discernible speech problem       Ves       No         Child has no discernible speech problem with       Ves       No         Child has no steerent examination       /       //         Tuberculin Test       Date       Type       Results         Mealth History (Serious or chronic linesses/injuries/surgeries)	Stereopsis		☐ Fail	-									
Child wears glasses? Ves No   Tested with glasses? Ves No   Referral made? Ves No   Speech/Language Lead Poisoning   Speech assesment completed Ves No   Child has no discernible speech problem Ves No   Speech valuation recommended Ves No   Child has no discernible speech problem with Date Type   Child has no discernible speech problem with Date Type   Realth History (Serious or chronic linesses/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   Ves No   Competition athletics   Ves No   Contact and collision sports   Ves No      HealthCare Provider's signature   Print name Phore			🗌 Fail				🗌 No		Comn	nents			
Tested with glasses? Yes No   Referral made? Yes No   Referral made? Yes No   Speech/Language Lead Poisoning   Speech assessment completed Yes No   Child has no discernible speech problem Yes No   Speech valuation recommended Yes No   Child has possible problem with Date Type   Child has possible problem with Yes No   Health History (Serious or chronic illnesses/injuries/surgeries) Image: Completed interset inte	Child wears glasses?		□ No		-	_	_						
Referral made?       Yes       No       Referral made?       Yes       No         Speech/Language       Lead Poisoning         Speech assessment completed       Yes       No       Date       Type       C       V       Results	-	Yes [	□ No	of a hearing s	specialist	Yes	🗌 No						
Speech assessment completed Yes No   Child has no discernible speech problem Yes No   Speech evaluation recommended Yes No   Child has possible problem with Tuberculin Test   Date Type Results     Health History (Serious or chronic illnesses/injuries/surgeries)     Physical Examination /     Seech evaluation recent examination     /     Physical Examination Date of most recent examination     /     Classroom and academic activities   Yes   No   Competition are advised, please specify	-	Yes [	□ No	Referral made?		🗌 Yes	🗌 No						
Speech assessment completed Yes No   Child has no discernible speech problem Yes No   Speech evaluation recommended Yes No   Child has possible problem with Tuberculin Test   Date Type C   V Results µg/dL   Tuberculin Test Date   Date Type   Results µg/dL     Tuberculin Test   Date Type   Results µg/dL     Tuberculin Test   Date Type     Results     Physical Examination   Date Yes     Physical Examination   Abnormalities as follows     Sechid able to participate fully in:   Classroom and academic activities   Yes   No   Competition athetics   Yes   No   Competition athetics   Yes   No   Consection athetics   Yes   No   Consection athetics   Yes   No   Consection athetics   Yes   No   If limitations are advised, please specify													
Child has no discernible speech problem Yes No   Speech evaluation recommended Yes No   Child has possible problem with Tuberculin Test   Date Type   Call V   Results Results   Health History (Serious or chronic illnesses/injuries/surgeries)	Speech/Language					-							
Speech evaluation recommended       Yes       No         Tuberculin Test       Date       Type       Results         Date       Type       Results	Speech assessment com	pleted	🗆 Ye	es 🗌 No									µg/dL
Child has possible problem with       Date	Child has no discernible	speech prob	lem 🗌 Ye		Date _			Туре	С	Πv	Results		µg/dL
Health History (Serious or chronic illnesses/injuries/surgeries)         Physical Examination Date of most recent examination       /	Speech evaluation recor	nmended	□ Ye	es 🗌 No	Tuberculi	n Test							
Physical Examination Date of most recent examination       /                Essentially normal             Abnormalities as follows                   Essentially normal             Abnormalities as follows                   Is this child able to participate fully in:             Classroom and academic activities             Yes             No             Competition athletics             Yes             No             Contact and collision sports             Yes             No             To estimate 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	Child has possible probl	em with			Date			Type _			Results		
Physical Examination Date of most recent examination       /                Essentially normal             Abnormalities as follows                   Essentially normal             Abnormalities as follows                   Is this child able to participate fully in:             Classroom and academic activities             Yes             No             Competition athletics             Yes             No             Contact and collision sports             Yes             No             To estimate 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					1								
Essentially normal       Abnormalities as follows         Is this child able to participate fully in:       Classroom and academic activities       Yes       No         Competition athletics       Yes       No       Contact and collision sports       Yes       No         If limitations are advised, please specify	Health History (Serious	or chronic illne	sses/injuries/su	rgeries)									
Essentially normal       Abnormalities as follows         Is this child able to participate fully in:       Classroom and academic activities       Yes       No         Competition athletics       Yes       No       Contact and collision sports       Yes       No         If limitations are advised, please specify													
Essentially normal       Abnormalities as follows         Is this child able to participate fully in:       Classroom and academic activities       Yes       No         Competition athletics       Yes       No       Contact and collision sports       Yes       No         If limitations are advised, please specify													
Essentially normal       Abnormalities as follows         Is this child able to participate fully in:       Classroom and academic activities       Yes       No         Competition athletics       Yes       No       Contact and collision sports       Yes       No         If limitations are advised, please specify													
Essentially normal       Abnormalities as follows         Is this child able to participate fully in:       Classroom and academic activities       Yes       No         Competition athletics       Yes       No       Contact and collision sports       Yes       No         If limitations are advised, please specify	<b>Physical Examination</b>	Date of most	recent examina	ation /	· /								
Classroom and academic activities       Yes       No       Physical education classes       Yes       No         Competition athletics       Yes       No       Contact and collision sports       Yes       No         If limitations are advised, please specify	Essentially normal	🗌 Abnorn	nalities as foll										
Classroom and academic activities       Yes       No       Physical education classes       Yes       No         Competition athletics       Yes       No       Contact and collision sports       Yes       No         If limitations are advised, please specify													
Classroom and academic activities       Yes       No       Physical education classes       Yes       No         Competition athletics       Yes       No       Contact and collision sports       Yes       No         If limitations are advised, please specify													
Classroom and academic activities       Yes       No       Physical education classes       Yes       No         Competition athletics       Yes       No       Contact and collision sports       Yes       No         If limitations are advised, please specify													
Competition athletics       Yes       No       Contact and collision sports       Yes       No         If limitations are advised, please specify		-						_	_				
If limitations are advised, please specify	Classroom and academ	ic activities											
Does this child have any physical, developmental or behavioral issues that may affect his/her educational process?         HealthCare Provider's signature         Print name         Phone         ( )	Competition athletics		Yes	🗆 No	Contact and	d collision	sports	☐ Yes		No			
HealthCare Provider's signature     Print name     Phone       (     )	If limitations are advised, pl	ease specify											
HealthCare Provider's signature     Print name     Phone       (     )													
HealthCare Provider's signature     Print name     Phone       (     )													
HealthCare Provider's signature     Print name     Phone       (     )													
HealthCare Provider's signature     Print name     Phone       (     )	Does this child have any ph	ysical, develop	mental or beha	avioral issues that n	nay affect his/	her educatio	nal proces	is?					
		· · · · · · · · · ·											
				r									
Address Date / /	HealthCare Provider's signat	ture		Print n	ame				F	hone (	)		
Address Date / /	Adduces									(	)		
	Audress									Jale	/	/	

State

ZIP

City

### Ohio Department of Health • School and Adolescent Health Oral Assessment

Student's name		Date of birth				
			/	/		
The following services have bee	<b>n performed</b> (please check all th	nat apply)				
Examination	☐ Fluoride application	Oral prophylaxis (cleaning)	Prescription for fluoride	supplement		
Orthodontic assessment	Radiographs	Dental sealant	Treatment (restoration,	pulp therapy)		
Other						
The following oral hygiene inst	ruction was provided (please c	heck all that apply)				
		Dietary counseling	Use of fluoride mouthrir	nse		
Other	-					
The following statements are ap	<b>oplicable</b> (please check all that ap	pply)				
All necessary preventive services	have been performed. (Fluoride tr	eatment, prophylaxis)				
No restorative services are requi						
Further treatment is indicated.(S		X.				
Further appointments have beer		/e)				
	eu.					
Comments						

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

# Ohio Department of Health • School and Adolescent Health Immunization Report

Student's name	Sex		Date of birth		
	□ Male	Female	/	/	

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 con	nplete dates (	(month, day, y	ear) <b>of vacci</b>	ne doses give	n
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 Pro	ovider 🗌 Pare	nt/Guardian [	Other		

Signature	Print name	Date
		/ /