

# 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, modifications, 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 development that you think would be helpful for the school to know.

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Form completed by

Relationship to student

Date

/ /

# Ohio Department of Health • School and Adolescent Health

## Health History

Student's name	Sex <input type="checkbox"/> Male <input type="checkbox"/> Female	Date of birth /    /
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**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?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Was infant born full term? <input type="checkbox"/> Yes <input type="checkbox"/> No	Did the infant have any sickness or problems? <input type="checkbox"/> Yes <input type="checkbox"/> 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? <input type="checkbox"/> About the same <input type="checkbox"/> Delayed <input type="checkbox"/> Advanced	

**Student Health Conditions**

<input type="checkbox"/> <b>YES</b> , my child receives regular medical/health care for the following conditions:	<input type="checkbox"/> <b>NO</b> medical conditions
<input type="checkbox"/> Allergies	<input type="checkbox"/> Diabetes
<input type="checkbox"/> Asthma	<input type="checkbox"/> Depression
<input type="checkbox"/> ADD/ADHD	<input type="checkbox"/> Ear problem/hearing difficulty
<input type="checkbox"/> Autism	<input type="checkbox"/> Emotional concerns
<input type="checkbox"/> Behavior concerns	<input type="checkbox"/> Headaches
<input type="checkbox"/> Birth/congenital malformations	<input type="checkbox"/> Heart problems
<input type="checkbox"/> Bone/muscle/joint problems	<input type="checkbox"/> Hemophilia
<input type="checkbox"/> Blood problems	<input type="checkbox"/> Juvenile arthritis
<input type="checkbox"/> Bowel/bladder problems	<input type="checkbox"/> Lead poisoning
<input type="checkbox"/> Cancer	<input type="checkbox"/> Migraines
<input type="checkbox"/> Cystic fibrosis	<input type="checkbox"/> Neuromuscular disorder
<input type="checkbox"/> Seizure disorder	<input type="checkbox"/> Sickle cell anemia
<input type="checkbox"/> Skin conditions	<input type="checkbox"/> Speech problems
<input type="checkbox"/> Traumatic brain injury	<input type="checkbox"/> Vision problems (glasses, contacts)
<input type="checkbox"/> Other _____	<input type="checkbox"/> Other _____
<input type="checkbox"/> Other _____	<input type="checkbox"/> Other _____
<input type="checkbox"/> Other _____	<input type="checkbox"/> 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
<input type="checkbox"/> Bee/Insect		
<input type="checkbox"/> Food		
<input type="checkbox"/> Medication		
<input type="checkbox"/> Other		



# Cardinal Stritch

Catholic High School & Academy

## Ohio Department of Health • School and Adolescent Health

### Oral Assessment

Student's name	Date of birth / /
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The following services have been performed (please check all that apply)

<input type="checkbox"/> Examination	<input type="checkbox"/> Fluoride application	<input type="checkbox"/> Oral prophylaxis (cleaning)	<input type="checkbox"/> Prescription for fluoride supplement
<input type="checkbox"/> Orthodontic assessment	<input type="checkbox"/> Radiographs	<input type="checkbox"/> Dental sealant	<input type="checkbox"/> Treatment (restoration, pulp therapy)
<input type="checkbox"/> Other _____			

The following oral hygiene instruction was provided (please check all that apply)

<input type="checkbox"/> Toothbrushing	<input type="checkbox"/> Flossing	<input type="checkbox"/> Dietary counseling	<input type="checkbox"/> Use of fluoride mouthrinse
<input type="checkbox"/> Other _____			

The following statements are applicable (please check all that apply)

<input type="checkbox"/> All necessary preventive services have been performed. (Fluoride treatment, prophylaxis)
<input type="checkbox"/> No restorative services are required at this time.
<input type="checkbox"/> Further treatment is indicated. (See comments)
<input type="checkbox"/> Further appointments have been arranged. (Orthodontic, restorative)
<input type="checkbox"/> Routine recall visits recommended.

Comments

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

**Cardinal Stritch Catholic Academy  
Kindergarten Health History**

CHILD'S NAME: \_\_\_\_\_ DOB \_\_\_\_\_

**Required** compulsory immunization law, **4 DPT**, **3 IPV/OPV**, **2 MMR** (on or after first birthday), the **Hepatitis B series** and **2 Varicella**

**IMMUNIZATION RECORD** (complete dates)

DPT            \*1. \_\_\_\_\_ \*2. \_\_\_\_\_ \*3. \_\_\_\_\_ \*4. \_\_\_\_\_ 5. \_\_\_\_\_

POLIO        \*1. \_\_\_\_\_ \*2. \_\_\_\_\_ \*3. \_\_\_\_\_ 4. \_\_\_\_\_ 5. \_\_\_\_\_

MMR           \*1. \_\_\_\_\_ \*2. \_\_\_\_\_

HEPATITIS B \*1. \_\_\_\_\_ \*2. \_\_\_\_\_ \*3. \_\_\_\_\_

VARICELLA \*1. \_\_\_\_\_ \*2. \_\_\_\_\_

HIB            1. \_\_\_\_\_ 2. \_\_\_\_\_ 3. \_\_\_\_\_ 4. \_\_\_\_\_

PREVNAR    1. \_\_\_\_\_ 2. \_\_\_\_\_ 3. \_\_\_\_\_ 4. \_\_\_\_\_

HEPATITIS A 1. \_\_\_\_\_ 2. \_\_\_\_\_

OTHER        Type \_\_\_\_\_ Date \_\_\_\_\_ Type \_\_\_\_\_ Date \_\_\_\_\_

**PHYSICIAN REPORT**

Screening test:

VISION  
Distance Acuity R \_\_\_\_\_ L \_\_\_\_\_  
Muscle Balance pass \_\_\_\_\_ fail \_\_\_\_\_  
Farsightedness pass \_\_\_\_\_ fail \_\_\_\_\_  
Color pass \_\_\_\_\_ fail \_\_\_\_\_  
Child wears glasses? yes \_\_\_ no \_\_\_  
Referral made? yes \_\_\_ no \_\_\_

HEARING (pass/fail)  
Impedance R \_\_\_\_\_ L \_\_\_\_\_  
Pure Tone R \_\_\_\_\_ L \_\_\_\_\_

Physical Examination: Essentially normal \_\_\_\_\_ Abnormalities as follows: \_\_\_\_\_

Is this child able to participate in all school activities? Yes \_\_\_ No \_\_\_ (please explain)

Date of exam \_\_\_\_\_

Physician's signature \_\_\_\_\_

Address \_\_\_\_\_

Phone \_\_\_\_\_

(may use office stamp)