

WORTHINGTON SCHOOLS
Worthington, Ohio

HEALTH HISTORY

Child's Name: _____ Enrollment Date: _____ Grade: _____
Last First Middle

Female: _____ Male: _____ Birthdate: _____ Height: _____ Weight: _____
Month/Day/Year

Medication History:

Present medications given daily: _____ Reason: _____

Past medications given regularly: _____ Reason: _____

Additional information: _____

Allergies: Please describe known allergies below. Indicate severity – *mild, moderate, or severe.*

Drugs _____ Food _____ Bees/Wasps _____ Animals _____
Plants _____ Pollen _____ Dust _____ Smoke _____
Latex _____ Molds _____ Mildew _____ Other _____

Treatment: Please describe allergy treatment this child currently receives or has received in the past:

Antihistamines _____ Other Medications _____ Inhalers _____

Desensitizing Shots _____ Epipen Required _____ Other _____

Injuries, Illnesses and Surgeries: Please list significant history below.

Injuries/Illnesses/Surgeries	Age of Child	Hospitalization Date
1. _____	_____	_____
2. _____	_____	_____
3. _____	_____	_____

Health History: Please check any conditions this child has experienced.

- | | |
|--|--|
| _____ Acne | _____ Hepatitis: <i>Type and Date:</i> _____ |
| _____ Attention Deficit Disorder | _____ Hypertension: _____ |
| _____ Anemia | _____ Measles: <i>Date:</i> _____ |
| _____ Arthritis | _____ Meningitis: <i>Type and Date:</i> _____ |
| _____ Asthma | _____ Multiple Ear Infections: <i>Last Episode:</i> _____ |
| _____ Congenital Abnormalities | _____ <i>Tubes? _____ Date: _____</i> |
| _____ Cancer: <i>Type:</i> _____ | _____ Mumps |
| _____ Chronic Bowel Problems: _____ | _____ Nervous Tic |
| _____ Cystic Fibrosis | _____ Physical Handicap: _____ |
| _____ Diabetes | _____ Poisoning: <i>Date:</i> _____ |
| _____ Depression | _____ Pregnancy |
| _____ Dermatitis | _____ Rheumatic Fever |
| _____ Eczema | _____ Rubella |
| _____ Encephalitis: <i>Date:</i> _____ | _____ Seizure Disorder: <i>Type:</i> _____ |
| _____ Emotional Problems: _____ | _____ Sickle Cell Disease |
| _____ Exposed to Cigarette Smoke Regularly | _____ Substance Abuse: _____ Tobacco _____ Alcohol _____ Drugs |
| _____ Frequent Respiratory Infections | _____ Spinal Curvature _____ Scoliosis _____ Kyphosis |
| _____ Hay Fever | _____ Suicide Risk |
| _____ Headaches: <i>Type:</i> _____ | _____ Urinary Tract Problems |
| _____ <i>Treatment:</i> _____ | _____ Visual Problems |
| _____ Heart Disease: <i>Type:</i> _____ | _____ Wears Glasses or Contacts. <i>Last Exam Date:</i> _____ |
| _____ Hearing Loss: _____ | _____ Other: _____ |
| _____ Hearing Aids: _____ | _____ |

PLEASE COMPLETE OTHER SIDE

Child's Name: _____
Last First Middle

Birthdate: _____
Month/Day/Year

Perinatal History:

Child's Birth Weight: _____
Mother's Age at Time of Child's Birth: _____
Length of Pregnancy: _____
Length of Labor: _____
Rh Incompatibility? _____
Complications? _____

After Delivery:

Did the baby experience any of the following?
If yes, please describe:
Cyanosis (blue skin color): _____
Jaundice (yellow skin color): _____
Infections: _____
Other: _____

Developmental History: Please indicate the approximate age that this child:

Walked alone _____
Bowel trained _____
Bladder trained _____
Dressed self _____

Spoke in two word sentences _____
Development compared to siblings or playmates:
Slower _____ Faster _____ Same _____
Other information _____

Sleep Habits or Disturbance:

How many hours does child sleep each night? _____ Any difficulties? _____
Mouth breather? _____ Snores? _____ Sleepwalks? _____ Bedwetting? _____

Speech Development: Has child had a speech problem? _____
Please describe: _____ Received speech therapy? _____

Dietary Status: Describe any concerns about child's nutrition: _____

Weight concerns? _____ Usually eat breakfast? _____ Avoid certain foods? _____
Other food related concerns: _____

Dental History:

Name of Dentist: _____ Date of Last Exam: _____
Special Dental Needs of Problems: _____

Special Needs:

Do you have other information or concerns about this child's physical or emotional health, growth and development, behavior, or family circumstances that you feel the school nurse should be aware of?

I request a conference with the school nurse. _____ Yes _____ No

Completed by: _____
Signature

Nurse's Comments: _____

PLEASE RETURN COMPLETED FORM TO YOUR CHILD'S SCHOOL NURSE.