New Albany Plain Local School District
School Health History

Date _____

Child's Full name _____
Last First Middle

Birth date: _____ Sex: □ Male □ Female

Father's name _____
Last First Middle

Mother's name _____
Last First Middle

Immunization Record : Mandatory for Enrollment

Please attach a separate sheet from your medical provider listing required immunizations including month/day/year.

Below is a list of medical questions that are asked for the purpose of assisting your child with any educational needs due to a health condition.

Perinatal History

1. Did the mother have any complications during the pregnancy or birth? □ Yes □ No
   If yes, explain: _____
2. Was this infant born: □ Full Term □ Early □ Late
3. What was the infant's birth weight? _____
4. Did the infant have any problems while in the nursery? □ Yes □ No
   If yes, explain: _____
   _____
5. How old was the mother when the child was born? _____
6. Were there any feeding problems? □ Yes □ No
   If yes, explain: _____
   _____

Family History

Please list this child's brothers and sisters

Name	Birth year	Sex	Name	Birth year	Sex

Developmental History

Please give the *approximate age* at which this child:

Walked alone _____ Spoke in sentences_____

Was toilet trained_____ Dressed self_____

How does this child's development compare to other children such as his/her brothers/sisters or playmates?

□ About the same □ Slower □ Faster

Health Conditions

Please check any that this child has had:

□ Abnormal spinal curvature	□ Concern about relation with siblings or friends	□ Heart disease, type	□ Seizures or epilepsy
□ Allergies or hay fever	□ Cystic Fibrosis	□ Hepatitis	□ Sickle cell disease
□ Anemia	□ Diabetes	□ Kidney disease, type	□ Stool soiling
□ Asthma or wheezing	□ Eczema	□ Measles (old fashioned or ten day)	□ Substance abuse (alcohol/drugs)
□ Bedwetting at night	□ Emotional problems	□ Meningitis or encephalitis	□ Suicide attempt
□ Behavior problem	□ Ear problems, poor hearing	□ Mumps	□ Toothaches or dental infections
□ Birth or congenital malformation	□ Eye problems, poor vision	□ Near-drowning or near suffocation	□ Urinary tract infection
□ Cancer, type	□ Frequent headaches	□ Nervous twitches or tics	□ Wetting during day
□ Chicken pox	□ Frequent skin infections	□ Poisoning	□ Other
□ Chronic diarrhea or constipation	□ Frequent sore throat infections	□ Rheumatic fever	□ Other

Allergies

Please list and describe allergies or reactions to:

1. Medicines/drugs _____
2. Foods/plants/animals/others _____
3. Bee or wasp sting _____
4. Recommended treatment if allergy is severe _____
5. Does this child have asthma that has been diagnosed by a doctor? □ Yes □ No If yes, What treatment has been prescribed? _____

_____

Injuries and Illnesses

Please list any severe injuries or illnesses:

Injuries/Illness (note if hospitalized)	Age

Does this child always wear seatbelts in cars? □ Yes □ No

Additional Information

1. What medications are given daily? _____
2. What medications are given frequently but not daily? _____
3. Do you anticipate the child will need medication administered at school? □ Yes □ No
   If yes, explain: _____
   _____
4. Does your child have any special health care needs? □ Yes □ No If yes, explain: _____
   _____
   _____
5. Does your child use any assistive devices ex? Hearing aids, glasses etc? □ Yes □ No If yes,
   Explain: _____
6. Do any family members have long-term illnesses such as diabetes, high blood pressure, etc?
   _____
7. Do you have other comments or concerns about this child's health, development, behavior, family or home life that you would like the school to be aware of? If yes, explain: _____
   _____

To adequately protect your child's well being this information will only be shared with the individuals who work directly with your child or school staff that are part of your child's learning community.

_____

Signature of Person completing form

Thank you for your time. If you have any questions now or any time during the school year please call the Health Office in your child's building.

Early Learning Center (PreK & K) - Brian Weikert, MSN, RN, LSN 614/413-8706
Primary Building (Grades 1-3) - Brian Weikert, MSN, RN, LSN 614/413-8608
Intermediate Building (Grades 4-6) - Brian Weikert and Susan Guy 614/413-3007
Middle School (Grades 7-8) - Susan Guy, MSN, RN, CNL, LSN 614/413-8512
High School – Susan Guy, MSN, RN, CNL, LSN 614/413-8317
District Nursing Coordinator, Susan Guy