



Student Health History Form

- Form must be completed and signed by parent at registration before student starts school.
- Form must be filed in student's health record at the assigned school building.

DEMOGRAPHIC DATA

Student's name: _____ Date enrolled: _____

Grade: _____ Birthdate: _____ Male: ☐ Female: ☐

Student's address: _____
street city state zip

Parent/Guardian names - Mother: _____ Father: _____

Phone: _____ Sibling names/ages: _____

MEDICATIONS

List medications given daily: _____

Reason given: _____

ALLERGIES

☐ Yes, indicate type of known allergies below ☐ None known

	Name/Type	Reaction	Treatment
Animals	_____	_____	_____
Drugs	_____	_____	_____
Environmental	_____	_____	_____
Foods	_____	_____	_____
Bees/wasps	_____	_____	_____

HEALTH HISTORY (Please check all conditions your child has or has had, and explain below)

☐ ADD/ADHD	☐ Developmental delays	☐ Menstrual problems	☐ Skin problems
☐ Arthritis/joints	☐ Diabetes	☐ Mental health issues	☐ Stomach problems
☐ Asthma	☐ Hearing problems	☐ Migraines	☐ Surgeries
☐ Birth defects	☐ Heart problems	☐ Physical limitations	☐ Urinary problems
☐ Blood disorder	☐ Hepatitis	☐ Relationship issues	☐ Visual problems
☐ Bowel problems	☐ Hospitalizations	☐ Seizures, tics or tremors	☐ Other
☐ Cancer	☐ Learning problems	☐ Serious illnesses	

Health concern checked above Age of child @ diagnosis Hospitalization date(s) Any long term problems

_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Student Health History Form (cont.)

Student's name: _____

PREGNANCY AND BIRTH HISTORY

Mom's age at time of pregnancy: _____

Any problems with mom or baby during the pregnancy? _____

Length of pregnancy: ____ weeks Length of labor: ____ hours Baby's birth weight: ____ lbs. ____ oz.

Any complications with delivery or baby after birth? _____

SPEECH AND LANGUAGE DEVELOPMENT

Are you concerned your child may have or has had a problem with speech or language development? _____

What are your concerns? _____

Any past speech therapy? _____ Where and when? _____

DIETARY

Do you have any concerns about your child's nutrition? _____

Any weight concerns? _____ Does your child eat breakfast? ☐ lunch? ☐ dinner? ☐

Does your child have any dietary restrictions? _____

OTHER CONCERNS

Please share other information or concerns about your child's emotional, physical, or developmental growth.

Please share any family circumstances or behavioral concerns you have about your child.

Is your child on an IEP or 504 Plan ☐ yes ☐ no

Please contact the Ohio Benefits website @ www.ohiomh.com or call 800-324-8680 to see if you may be eligible for individual, family, or student Medicaid or Medicare insurance.

Check if you would like a conference with the school nurse. ☐

Parent/Guardian

Printed name: _____

Relationship: _____

Parent/Guardian

Signature: _____

Date: _____