Ohio School Health History Form
PRESCHOOL VERSION

Form must be completed and returned to Cloverleaf Elementary School.

CHILD'S NAME (FIRST, MIDDLE, LAST) :

SEX: ☐ male ☐ female | BIRTHDATE: month day year

CHILD'S ADDRESS:

FATHER'S NAME: MOTHER'S NAME:

FATHER'S ADDRESS: WORK PHONE: HOME PHONE:

MOTHER'S ADDRESS: WORK PHONE: HOME PHONE:

PARENT(S) ARE: ☐ Married ☐ Separated ☐ Divorced ☐ Widowed ☐ Single Parent

WITH WHOM DOES CHILD LIVE? Name Address

WHO IS THIS CHILD'S LEGAL GUARDIAN?

WITH WHOM DOES THE CHILD STAY DURING THE DAY? (NAME OF PERSON & RELATIONSHIP TO CHILD OR NAME OF CARE CENTER)

FAMILY HISTORY (please list this child's brothers and sisters)

Name	BirthDate	Gender M/F	Health Concerns? Y/N	In School? Y/N	If so, where?
1.					
2.					
3.					
4.					
5.					

PERINATAL HISTORY

AT WHAT MONTH DID MOTHER BEGIN PRENATAL CARE:

DID MOTHER HAVE ANY UNUSUAL PHYSICAL/EMOTIONAL ILLNESS DURING PREGNANCY? ☐ yes ☐ no
IF YES, EXPLAIN BRIEFLY:

MOTHER'S AGE AT CHILD'S BIRTH: | INFANT WAS BORN: ☐full term ☐early ☐late | INFANT BIRTH WEIGHT:

DID THE INFANT HAVE ANY SICKNESS OR PROBLEMS WHILE IN THE NURSERY? ☐ yes ☐ no
IF YES, EXPLAIN BRIEFLY:

DEVELOPMENTAL HISTORY

AGE WHEN CHILD: ______ walked alone ______ was toilet trained ______ dressed self ______ spoke first words

THIS CHILD IS USUALLY: ☐ very active ☐ normally active ☐ rather inactive

CHILD'S DEVELOPMENT COMPARES TO OTHER CHILDREN'S: ☐ about the same ☐ slower ☐ faster

DO YOU HAVE CONCERNS ABOUT HOW CHILD GETS ALONG WITH OTHER CHILDREN? ☐ yes ☐ no
IF YES, EXPLAIN BRIEFLY:

HAS THE CHILD ATTENDED ANY EARLY INTERVENTION OR PRESCHOOL PROGRAM? ☐ yes ☐ no
IF YES, WHERE AND WHEN:

ALLERGIES - Please list and describe allergies or reactions to:

MEDICINES/DRUGS:

FOODS/PLANTS/ANIMALS/OTHER:

RECOMMENDED TREATMENT IF ALLERGY IS SEVERE:

COMMENTS/CONCERNS ABOUT CHILD'S HEALTH, DEVELOPMENT, BEHAVIOR, HOME LIFE:

Completed by: ______________________ Date: ______________

PHYSICIAN COMPLETED INFORMATION:

HEALTH CONDITIONS - Please check any that this child has had:

___ Abnormal spinal curvature *(scoliosis, etc.)*
___ Allergies or hay fever
___ Anemia
___ Arthritis
___ Asthma
___ Behavior problems
___ Birth/congenital malformation
___ Cancer, Type ________________
___ Chicken pox
___ Concern about siblings/ friend relationship
___ Cystic Fibrosis
___ Diabetes
___ Diarrhea/constipation *(chronic)*
___ Eczema
___ Emotional problems
___ Headaches *(frequent)*
___ Heart disease
___ Hepatitis
___ Kidney disease
___ Measles *(10-day)*
___ Meningitis/encephalitis
___ Mumps
___ Rheumatic Fever
___ Rubella *(3-day measles)*
___ Seizures/epilepsy
___ Sickle cell disease
___ Skin rashes *(frequent)*
___ Stool soiling
___ Throat infections *(frequent)*
___ Tics/nervous twitches
___ Urinary tract infections
___ Wetting *(daytime/night)*

LIST ANY FOOD SUPPLEMENTS OR MODIFIED DIETS CURRENTLY BEING ADMINISTERED TO THE CHILD:

Immunizations: Please list the dates of the following immunizations (month/day/year) or attach copy of immunization record

DTAP DPT or DT					
Polio					
MMR (measles, mumps, rubella)					
Hepatitis B					
Varicella					
HIB (Haemophilus influenza type B					
Hepatitis A					
Other					

Injuries/Illnesses/Surgeries

Screening Results:

	Date	Results	Not Screened	Further Action/Description
Height				
Weight				
BP				
Lead				
Hematocrit				
Vision				
Hearing				
BMI				

Based on completed examination, this child is eligible to participate in group-based preschool. ☐ **Yes** ☐ **No**

Phsician's Name: Physician's Signature:

Address: DATE: