

DOVER CITY SCHOOLS

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 / / |
| Address | | Phone |

Family Health History Please list allergies, heart problems, diabetes, cancer or other serious health conditions.

| Father's Name | Date of Birth | Health History |
|------------------------------|---------------|----------------|
| | | |
| Mother's Name | Date of Birth | Health History |
| | | |
| Brothers and Sisters Name(s) | Date of Birth | Health History |
| 1. | | |
| 2. | | |
| 3. | | |
| 4. | | |

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 | |
| Infant birth weight _____ | Mother's age when this child was born _____ | |
| 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"/> YES , my child receives regular medical/health care for the following conditions: <input type="checkbox"/> NO medical conditions | | |
| <input type="checkbox"/> Allergies (give details on next page) | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Seizure disorder |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Depression | <input type="checkbox"/> Sickle cell anemia |
| <input type="checkbox"/> ADD/ADHD | <input type="checkbox"/> Ear problem/hearing difficulty | <input type="checkbox"/> Skin conditions |
| <input type="checkbox"/> Autism | <input type="checkbox"/> Emotional concerns | <input type="checkbox"/> Speech problems |
| <input type="checkbox"/> Behavior concerns | <input type="checkbox"/> Headaches | <input type="checkbox"/> Traumatic brain injury |
| <input type="checkbox"/> Birth/congenital malformations | <input type="checkbox"/> Heart problems | <input type="checkbox"/> Vision problems (glasses, contacts) |
| <input type="checkbox"/> Bone/muscle/joint problems | <input type="checkbox"/> Hemophilia | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Blood problems | <input type="checkbox"/> Juvenile arthritis | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Bowel/bladder problems | <input type="checkbox"/> Lead poisoning | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Migraines | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Cystic fibrosis | <input type="checkbox"/> Neuromuscular disorder | <input type="checkbox"/> Other _____ |

Please explain any conditions above or any reasons for hospitalizations.

Health History continued

| 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 | | |
| 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? <input type="checkbox"/> Yes <input type="checkbox"/> No If YES, please explain. _____ _____ | | |
| Does the student require any special procedures and/or treatments for their health condition(s)? <input type="checkbox"/> Yes <input type="checkbox"/> 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. _____ _____ _____ _____ _____ | | |

| | | |
|-------------------|-------------------------|---------------|
| Form completed by | Relationship to student | Date / / |
|-------------------|-------------------------|---------------|

DOVER CITY SCHOOLS

Ohio Department of Health • School and Adolescent Health

Physical Examination

| | | | | | |
|----------------|--------|--|--|----------------------|--|
| Student's Name | | Sex <input type="checkbox"/> Male <input type="checkbox"/> Female | | Date of Birth / / | |
| Height | Weight | BMI percentile | | BP | |

Screening Tests

| Vision | Hearing | Postural |
|---|--|---|
| Date performed / / | Date performed / / | Date performed / / |
| Distance Acuity <input type="checkbox"/> R <input type="checkbox"/> L Muscle Balance <input type="checkbox"/> Pass <input type="checkbox"/> Fail Stereopsis <input type="checkbox"/> Pass <input type="checkbox"/> Fail Color <input type="checkbox"/> Pass <input type="checkbox"/> Fail Child wears glasses? <input type="checkbox"/> Yes <input type="checkbox"/> No Tested with glasses? <input type="checkbox"/> Yes <input type="checkbox"/> No Referral made? <input type="checkbox"/> Yes <input type="checkbox"/> No | Pure Tone Right ear <input type="checkbox"/> Pass <input type="checkbox"/> Fail Left ear <input type="checkbox"/> Pass <input type="checkbox"/> Fail Child wears hearing aid? <input type="checkbox"/> Yes <input type="checkbox"/> No Child under the care of a hearing specialist? <input type="checkbox"/> Yes <input type="checkbox"/> No Referral made? <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> No abnormality noted <input type="checkbox"/> Screening not done <input type="checkbox"/> Referral made Comments _____ _____ |

Speech/Language

| | |
|---|--|
| Speech assessment completed | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Child has no discernible speech problem | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Speech evaluation recommended | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Child has possible problem with _____ | |

Lead Poisoning

| |
|--|
| <input type="checkbox"/> Date _____ Type <input type="checkbox"/> C <input type="checkbox"/> V Results _____ µg/dL |
| <input type="checkbox"/> Date _____ Type <input type="checkbox"/> C <input type="checkbox"/> V Results _____ µg/dL |
| Tuberculin Test Date _____ Type _____ Results _____ |

Health History (Serious or chronic illnesses/injuries/surgeries)

Physical Examination Date of most recent examination / /

| | |
|---|--|
| <input type="checkbox"/> Essentially normal <input type="checkbox"/> Abnormalities as follows _____ _____ | |
| Is this child able to participate fully in: Classroom and academic activities <input type="checkbox"/> Yes <input type="checkbox"/> No Competition athletics <input type="checkbox"/> Yes <input type="checkbox"/> No | Physical education classes <input type="checkbox"/> Yes <input type="checkbox"/> No Contact and collision sports <input type="checkbox"/> Yes <input type="checkbox"/> No |
| If limitations are advised, please specify _____ _____ _____ | |
| Does this child have any physical, developmental or behavioral issues that may affect his/her educational process? _____ _____ _____ | |

| | | |
|---------------------------------|------------|--------------|
| HealthCare Provider's signature | Print name | Phone () |
| Address | | Date / / |
| City | State | Zip |

Ohio Department of Health • School and Adolescent Health
Immunization Report
 (Requirements for kindergarten are marked with an "**".)

| | | |
|----------------|--|--------------------------------|
| Student's name | Sex <input type="checkbox"/> Male <input type="checkbox"/> Female | Date of birth / / |
|----------------|--|--------------------------------|

Students are required to be immunized in accordance with Ohio law (Ohio Revised Code 3313.67/3313.671).
 A copy of the child's immunization record may be attached or dates may be entered below.
 Please note, the month, day, and year for each immunization should be on record.

* 5 doses, any combination

| Vaccine | Record complete dates (month, day, year) of vaccine doses given | | | | | |
|---|---|--|--|--|--|--|
| Diphtheria, Tetanus, Pertussis (DTP) | | | | | | |
| DTaP, Tdap | | | | | | |
| DT, Td | | | | | | |
| Polio *4 doses | | | | | | |
| Hepatitis B (HBV) *3 doses | | | | | | |
| Measles, Mumps, Rubella (MMR) *2 doses | | | | | | |
| Varicella (Chickenpox) *2 doses Varivax or verification of the Disease | | | | | | |
| Hepatitis A | | | | | | |
| Meningococcal (MCV4, MPSV4) | | | | | | |
| Pneumococcal (PCV) | | | | | | |
| Measles (Rubeola) only | | | | | | |
| Rubella only | | | | | | |
| Mumps only | | | | | | |
| Haemophilus influenza Type b (Hib) | | | | | | |
| Influenza | | | | | | |
| Other | | | | | | |

This information was provided by Health Care Provider Parent/Guardian Other _____

| | | |
|-----------|------------|-----------------------|
| Signature | Print name | Date / / |
|-----------|------------|-----------------------|

DOVER CITY SCHOOLS

Ohio Department of Health • School and Adolescent Health Oral Assessment

| | |
|----------------|-------------------|
| Student's name | Date of birth / / |
|----------------|-------------------|

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 mouth rinse |
| <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 |