School Health History

Northmont City Schools
4001 Old Salem Road
Englewood, Ohio 45322

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02/02

Child's Full Name:	Last	First	Middle
Address:	Street	City/Zip	Phone
Sex: Male ☐ Female ☐	Birth date: month	day	year

Family History

Please list this child's brothers and sisters (siblings)

Name	Birth Year	Sex	Name	Birth Year	Sex
1.			5.		
2.			6.		
3.			7.		
4.			8.		

Perinatal History

Did the mother have any unusual physical or emotional illness during this pregnancy? ☐yes ☐no
If yes, explain briefly:

How old was the mother when this child was born?
Was this infant born: ☐full term ☐early ☐late
What was this infant's birth weight?

Did the infant have any sickness or problems while in the nursery? ☐yes ☐no
If yes, explain briefly:

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 or her siblings or playmates?
☐ about the same ☐ slower ☐ faster

I. Health Conditions- please check any that this child has had.

- ☐ Abnormal spinal curvature (scoliosis, etc.)
- ☐ Allergies or hay fever
- ☐ Anemia
- ☐ Asthma mild
- ☐ Asthma (requires medication)
- ☐ Bedwetting at night
- ☐ Bedwetting during day
- ☐ Behavior problem
- ☐ Birth or congenital malformation
- ☐ Cancer, type ____________
- ☐ Chicken Pox
- ☐ Chronic diarrhea or constipation
- ☐ Concern about relation with siblings or friends
- ☐ Cystic Fibrosis
- ☐ Diabetes
- ☐ Eczema
- ☐ Emotional problems
- ☐ Ear problems, poor hearing
- ☐ Eye problems, poor vision
- ☐ Frequent headaches
- ☐ Frequent skin infections
- ☐ Frequent sore throats
- ☐ Heart disease, type ____________
- ☐ Hepatitis
- ☐ Kidney disease
- ☐ Measles
- ☐ Meningitis or encephalitis
- ☐ Mumps
- ☐ Near-drowning or near-suffocation
- ☐ Nervous tics
- ☐ Poisoning ____________
- ☐ Pregnancy
- ☐ Seizures
- ☐ Sickle Cell
- ☐ Stool soiling
- ☐ Substance abuse (alcohol, drugs)
- ☐ Suicide attempt
- ☐ Toothaches or dental infections
- ☐ Urinary tract infections
- ☐

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II. Allergies--Please list allergy and describe reaction to:

Has Medication allergy to: 1. ______________ Reaction is: ______________

2. ______________ ______________

3. ______________ ______________

Has food/plant/animal allergy to:

1. ______________ Reaction is: ______________

2. ______________ ______________

3. ______________ ______________

Treatment for severe allergy reaction is:

III. Asthma

Asthma attacks are brought on by:

Daily medications for Asthma are:

As needed medications for Asthma are:

IV. Injuries and Illnesses--Please list any severe injuries or illnesses:

Injury or illness	Age of child	If hospitalized, how long
fdsfs		

V. Additional Information

Medication taken daily other than those listed above:

Is your child usually ☐ very active ☐ normally active ☐ rather active

Do you have any concern about how your child gets along with other children?

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 briefly:

Form completed by: ______________ Date: __________ Relationship to child: ______________