School Year 2017-2018

ANNUNCIATION CATHOLIC SCHOOL
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Ohio School Health History

Child's Name	**Gender** (circle one) Male Female	**Age**	**Birthdate**

To be completed by parent for student record

Who is the child's legal guardian?	**Who does the child live with?**	**Child's Address:**

Parent/Guardian	**Parent/Guardian Address**	**Home Phone Number**

Family History

Please list first and last name of all child's family members, including parents and siblings.

Name	Birthdate	Gender	Health Concerns	Is the child in school?	If so, where?
1.					
2.					
3.					
4.					
5.					

Perinatal History

Did the mother have any unusual physical or emotional illness during this pregnancy? (circle one) Yes No
If yes, explain briefly.

How old was the mother when the child was born? _____ **Was the infant born** (circle one): Full term Early Late
What was the infant's birth weight? _____ lbs _____ oz

Did the infant have any sickness or problems? (circle one) Yes No
If yes, explain briefly.

Development History

Please give the approximate age at which this child:

Walked alone: _____ **Spoke in sentences:** _____
Toilet trained: _____ **Dressed self:** _____

How does this child's development compare to other children, such as siblings or playmates? (circle one)
About the same Delayed Advanced

Allergies

Please list and describe allergies or reactions.

Medications/drugs

Foods/plants/animals/other

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Injuries, Illnesses & Hospitalizations

Please list any severe injuries, illnesses and hospitalizations, including inpatient and outpatient surgical procedures.

Injuries/Illnesses/Hospitalizations	Age	If hospitalized, please explain

Does your child always wear a seatbelt while riding in automobiles? (circle one) Yes No

Does the student wear a helmet when bicycling, skating/rollerblading or riding a motorcycle? (circle one) Yes No

Medical Information

Please describe any medications that your child takes daily and/or frequently.

Name of Medication	What is the medication taken for?	How often is the medication taken? What time is it administered?

Health Conditions

Please check any medical conditions that the child currently has or has had in the past.

- ❑ **Abnormal spinal curvature (Scoliosis)**
- ❑ **Allergies/hay fever**
- ❑ **Anemia**
- ❑ **Anaphylactic reaction**
- ❑ **Asthma or wheezing**
- ❑ **Attention deficit disorder (ADD)**
- ❑ **Behavior problem**
- ❑ **Birth or congenital malformation**
- ❑ **Cancer type _____**
- ❑ **Chickenpox when _____**
- ❑ **Chronic diarrhea or constipation**
- ❑ **Chronic ear infections tubes _____**
- ❑ **Concern about relation with siblings or friends**
- ❑ **Cystic Fibrosis**
- ❑ **Diabetes**
- ❑ **Eczema/Chronic skin condition**
- ❑ **Emotional problems**
- ❑ **Eye problems, poor vision**
- ❑ **Frequent headaches**
- ❑ **Frequent sore throats**
- ❑ **Heart disease type _____**
- ❑ **Hemophilia**
- ❑ **Hepatitis**
- ❑ **HIV positive**
- ❑ **Hyperactivity**
- ❑ **Juvenile Arthritis**
- ❑ **Kidney disease type _____**
- ❑ **Measles (10 day)**
- ❑ **Meningitis or Encephalitis**
- ❑ **Mumps**
- ❑ **Mutism**
- ❑ **Near-drowning/Near-suffocation**
- ❑ **Nervous twitches or tics**
- ❑ **Poisoning**
- ❑ **Rheumatic fever**
- ❑ **Seizure disorder/Epilepsy**
- ❑ **Sickle Cell Disease**
- ❑ **Speech difficulties**
- ❑ **Stool soiling**
- ❑ **Toothaches or dental problems**
- ❑ **Tourette's Syndrome**
- ❑ **Urinary tract infections**
- ❑ **Wetting during the day or night**

Completed by _____ **Date** _____