



## Groveport Madison Local Schools Student Health History

Student Name \_\_\_\_\_ Birthdate \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ Zip \_\_\_\_\_

Student's Telephone \_\_\_\_\_

Physician's Name \_\_\_\_\_ Telephone \_\_\_\_\_

Physician's Address \_\_\_\_\_ City \_\_\_\_\_ Zip \_\_\_\_\_

**Allergies** – Please list and describe allergies or reactions to:

Bee/insect stings (if severe)

\_\_\_\_\_

Foods/plants/animals/other

\_\_\_\_\_

Recommended treatment if allergy is severe

\_\_\_\_\_

**Medications** – Please list type or name of medication:

\_\_\_\_\_

\_\_\_\_\_

Medications given: \_\_\_\_\_ daily \_\_\_\_\_ weekly \_\_\_\_\_ seasonal

What medications are given frequently but not daily?

\_\_\_\_\_

**Health Conditions** – Please check all that pertain to this student:

- |  |  |   |
|--|--|---|
| <input type="checkbox"/> Abnormal spinal curvature (scoliosis) | <input type="checkbox"/> Eye problems, poor vision         | <input type="checkbox"/> Poisoning                        |
| <input type="checkbox"/> Allergies or hay fever                | <input type="checkbox"/> Frequent headaches                | <input type="checkbox"/> Poor hearing                     |
| <input type="checkbox"/> Anemia                                | <input type="checkbox"/> Frequent skin infections          | <input type="checkbox"/> Pregnancy                        |
| <input type="checkbox"/> Arthritis                             | <input type="checkbox"/> Frequent sore throat infections   | <input type="checkbox"/> Rheumatic fever                  |
| <input type="checkbox"/> Asthma or wheezing                    | <input type="checkbox"/> Heart disease – type _____        | <input type="checkbox"/> Rubella _____ date               |
| <input type="checkbox"/> Bedwetting at night                   | <input type="checkbox"/> Hepatitis A ___ B _____           | <input type="checkbox"/> Scarlet Fever _____ date         |
| <input type="checkbox"/> Behavior problem                      | <input type="checkbox"/> Kidney disease – type _____       | <input type="checkbox"/> Seizures or Epilepsy             |
| <input type="checkbox"/> Birth or congenital malformation      | <input type="checkbox"/> Whooping Cough                    | <input type="checkbox"/> Sickle Cell Disease              |
| <input type="checkbox"/> Blood disorders                       | <input type="checkbox"/> Measles (rubella) _____ date      | <input type="checkbox"/> Stool soiling                    |
| <input type="checkbox"/> Cancer – Type _____                   | <input type="checkbox"/> Meningitis or encephalitis        | <input type="checkbox"/> Substance abuse (alcohol, drugs) |
| <input type="checkbox"/> Chicken Pox _____ date                | <input type="checkbox"/> Mononucleosis _____ date          | <input type="checkbox"/> Suicide attempt                  |
| <input type="checkbox"/> Chronic diarrhea or constipation      | <input type="checkbox"/> Ear infections (more than 3)      | <input type="checkbox"/> Toothaches or dental infections  |
| <input type="checkbox"/> Cystic Fibrosis                       | <input type="checkbox"/> Mumps _____ date                  | <input type="checkbox"/> Tuberculosis                     |
| <input type="checkbox"/> Diabetes                              | <input type="checkbox"/> Near-drowning or near-suffocation | <input type="checkbox"/> Urinary tract infections         |
| <input type="checkbox"/> Eczema                                | <input type="checkbox"/> Nervous twitches or tics          | <input type="checkbox"/> Wetting during the day           |
| <input type="checkbox"/> Emotional problems                    | <input type="checkbox"/> Nervous conditions _____          | <input type="checkbox"/> <b>None of the above applies</b> |



**Injuries and Illnesses** – Please list any severe injuries or illnesses: Age of Child If hospitalized (date)

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**Prenatal 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 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 appropriate age at which the child:

Walked along \_\_\_\_\_ Toileted trained \_\_\_\_\_ Spoke in sentences \_\_\_\_\_ Dressed self \_\_\_\_\_

How does this child's development compare to other children, such as his/her brothers/sisters or playmates:

About the same  Slower  Faster

Has your child attended?  Special School  Special Classes  Special Clinic  Therapy

Name of Facility \_\_\_\_\_ Briefly explain

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Do you have any concern about how your child gets along with other children? Yes No

If yes, please briefly explain: \_\_\_\_\_

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