

GROVEPORT MADISON LOCAL SCHOOL DISTRICT

Health History

School _____ Date _____

Student's Name _____ Birth date _____

Address _____ Zip _____

Student's Telephone _____

Physician's Name _____ Telephone _____

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

PLEASE COMPLETE THE REVERSE SIDE

Injuries and Illnesses – Please list any severe injuries or illnesses:

<u>Injury or Illness</u>	<u>Age of Child</u>	<u>If hospitalized (date)</u>
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

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 _____ Was toilet 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

Please name facility _____ Briefly explain _____

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 _____

Information completed by _____

Relation to child _____