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:

____ Abnormal spinal curvature (scoliosis)
____ Allergies or hay fever
____ Anemia
____ Arthritis
____ Asthma or wheezing
____ Bedwetting at night
____ Behavior problem
____ Birth or congenital malformation
____ Blood disorders
____ Cancer – type __________________________
____ Chicken Pox ________________________ date
____ Chronic diarrhea or constipation
____ Cystic Fibrosis
____ Diabetes
____ Eczema
____ Emotional problems
____ Eye problems, poor vision
____ Frequent headaches
____ Frequent skin infections
____ Frequent sore throat infections
____ Heart disease – type ______________________
____ Hepatitis A ___ B ___ _______________date
____ Kidney disease – type _____________________
____ Whooping Couth

____ Measles (rubella) _____________ date
____ Meningitis or encephalitis
____ Mononucleosis _____________ date
____ Ear infections (more than 3)
____ Mumps _____________ date
____ Near-drowning or near-suffocation
____ Nervous twitches or tics
____ Nervous conditions ________________
____ Poisoning
____ Poor hearing
____ Pregnancy
____ Rheumatic fever
____ Rubella _____________ date
____ Scarlet Fever _____________ date
____ Seizures or Epilepsy
____ Sickle Cell Disease
____ Stool soiling
____ Substance abuse (alcohol, drugs)
____ Suicide attempt
____ Toothaches or dental infections
____ Tuberculosis
____ Urinary tract infections
____ Wetting during the day
____ **None of the above apply to this student**

PLEASE COMPLETE THE REVERSE SIDE

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

Injury or Illness	Age of Child	If hospitalized (date)
___	___	___
___	___	___
___	___	___
___	___	___

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 ____