School Health Record
Summit County Health District

School_____
Date Enrolled_____
(To be completed by parent/guardian.) Entering Grade_____

Child's Name	Birth date

Parent/Guardian	Home phone number

Immunizations:

Ohio Law describes minimum requirements for school entrance. If you have any questions please speak with your school nurse.

Type:	Record Month/Day/Year
DTaP, DPT, DT	_____ _____ _____ _____ _____
Td, TDaP	_____
Polio, OPV, IPV	_____ _____ _____ _____
MMR	_____ _____
Hepatitis B	_____ _____ _____
Varivax (chickenpox)	_____ _____ (date of vaccine or disease)
HIB	_____ _____ _____ _____
Prevnar (pneumococcal)	_____ _____ _____ _____ Recommended
TB Test	_____ Result: Neg. _____ or Pos._____
Other_____	_____

Perinatal History

Did the mother have any unusual physical or emotional illness while pregnant with this child?
□ Yes □ No If yes, please explain:

How old was the mother When this child was born?	Was this infant: □ 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, please explain:

Developmental History:

Please give the approximate age at which this child: walked alone _____ was toilet trained _____
spoke in sentences_____ dressed self _____

How does this child's development compare to other children, such as his or her brothers/sisters or playmates?
About the same_____ delayed_____ advanced_____

Health Conditions: Please check any that this child has had.

❑ Allergies	❑ Chickenpox when_____	❑ Heart Disease
❑ Anaphylactic reaction	❑ Cystic Fibrosis	❑ Hepatitis
❑ Asthma or wheezing	❑ Diabetes	❑ Juvenile arthritis
❑ Attention Deficit Disorder	❑ Ear problems/ poor hearing	❑ Kidney disease
❑ Behavioral concerns	❑ Eczema/ skin conditions	❑ Meningitis/ Encephalitis
❑ Birth/ congenital malformations	❑ Emotional concerns	❑ Seizures/ Epilepsy
❑ Blood problems	❑ Eye problems/ poor vision	❑ Speech difficulties
❑ Bone/ joint problems	❑ Frequent headaches	❑ Toothaches/ dental problems
❑ Bowel problems	❑ Frequent sore throats	❑ Urinary tract infections
❑ Cancer	□ Head injury, any type	❑ Wetting during day or night

School Health Record

Injuries, Illnesses & Hospitalizations: Please explain.

Current Health: Please tell us about any health conditions your child has currently:

Allergies:	
Allergy to:	Reactions / Recommended Treatment if Severe

Medications: List medicine your child takes regularly.		
Name	Taken for	How often? What time?

If your child must take medication at school, please request **Medication Authorization forms** to be completed by you and your child's physician.

Does your child need special assistance at school? Explain:

Is your child enrolled in a special education class? _____ Yes _____No

Family History List family members, relationship to student, birth date and significant health concerns.			
Name	Relationship	Birth date	Health Concern
1.			
2.			
3.			
4.			
5.			
6.			

Would you like to talk to a nurse about community resources, Healthy Start Insurance, BCMH or SSI?
Yes_____ No_____

If you have questions about your child's health or community services that may be available to you, call the Summit County Health District, (330) 926-5615, or 1-877-687-0002 and ask to speak to a Public Health Nurse.

School Health Record School _____

Physician's Report

Child's name	Sex □ Male □ Female	Age	Date

Objective data

Height (%)	Weight (%)	B.P. / Pulse

Screening Tests

VISION	Date			HEARING	Date		
Distance Acuity	right _____	left _____		Pure tone testing	(20 dB @ 1000, 2000, 4000 Hz)		
Tested with glasses?	□ yes	□ no					
Muscle Balance	□ pass	□ fail	□ not done	Right ear	□ pass	□ fail	□ not done
Farsightedness	□ pass	□ fail	□ not done	Left ear	□ pass	□ fail	□ not done
Random Dot E	□ pass	□ fail	□ not done	Other tests (specify)	_____		
Color vision with pseudo-isochromic plates	□ pass	□ fail	□ not done	Child wears hearing aid?	□ yes	□ no	
Child wears glasses?	□ yes	□ no		Tested with Hearing aid?	□ yes	□ no	
Glasses worn for:	□ distance	□ reading	□ at all times	Referral made?	□ yes	□ no	
Referral made?	□ yes	□ no					

Speech/Language

Speech assessment: □ done □ not done □ Child has no discernible speech problem
Child has possible problem with: □ Articulation □ Rhythm □ Voice □ Language
Speech Evaluation recommended: □ Yes □ No

Laboratory Tests

□Hematocrit /Hemoglobin	□ Urine protein	□ Urine blood	□ Urine glucose	□ Other:_____

Physical Examination:

Date examined _____

□ Essentially normal Abnormalities as follows: _____

_____

_____

_____

_____

Is this child able to participate fully in the following:

A. Classroom and academic activities? □ yes □ no
B. Physical education classes? □ yes □ no
C. Competitive athletics? □ yes □ no
D. Contact and collision sports? □ yes □ no

If limitations are advised, please specify those limitations:

_____

_____

_____

If this child has any physical, developmental or behavioral problems, how can the school assist with special programs, placement or attention?

_____

_____

_____

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Medications:

If this child is taking any medication, please list medication and reason for taking:	
Medication	Reason for taking

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Varivax (chickenpox)	_____	_____ (date of vaccine or disease)			
HIB	_____	_____	_____	_____	
Prevnar (pneumococcal)	_____	_____	_____	_____ Recommended.	
TB Test	_____	Result: Neg. _____ or Pos._____ Optional			
Other_____	_____				

Please print or stamp:

Doctor's name	Doctor's signature
Address	Date signed
Phone	

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School _____

Child's Name	Birth date

Parent / Guardian	Home phone number

Dentist's Report

The following services have been performed:

- □ Examination
- □ Radiographs
- □ Prescription for fluoride supplements
- □ Diagnosis
- □ Oral prophylaxis
- □ Topical application of fluoride

The following oral hygiene instruction was provided:

- □ Tooth brushing
- □ Diet counseling reflecting relation of diet to dental health
- □ Flossing
- □ Home/school use of fluoride mouth rinse

The following statements are applicable:

- □ All necessary services have been performed
- □ Further treatment is indicated
- □ No restorative services are required at this time
- □ Further appointments have been arranged

Comments: _____

_____

_____

_____

_____

Please Print or Stamp:

Dentist's name	Dentist's signature
Address	Date signed
Phone	