OHIO SCHOOL HEALTH HISTORY

Instructions:

1. A parent or guardian must complete pages 1-3.

2. A physician must fill out and sign pages 4-5.

3. The oral assessment on page 6 is optional, but highly recommended.

4. Please document on the health history form and inform the school nurse if your child has any health problems, allergies, or will be taking medication at school. If your child has an allergy, please have your physician document the prescribed treatment on the Physical Assessment form or appropriate medication form. Please inform the district nurse if your child takes medication at home.

5. Please attach a copy of your child's immunization records to this Ohio School Health History.

6. Vision and Hearing Screenings of all Kindergarten students will be done next fall. Parents will be notified by a written referral if your child will need further medical evaluation.

Ohio Immunization Summary for School Attendance, 2025-2026

Vaccine/Grade	K	1st	2nd	3rd	4th	5th	6th	7th	8th	9th	10th	11th	12th
DTaP Diphtheria, Tetanus, Pertussis	4 or more doses												
Hep B Hepatitis B	3 or more doses												
MMR Measles, Mumps, Rubella	2 doses												
Polio	3 or more doses												
Varicella (Chickenpox)	2 doses												
Tdap Tetanus, Diphtheria, Pertussis								1 dose					
MCV4 Meningococcal ACWY								1st dose					2nd dose

Important Notes:

- Vaccine should be administered according to the most recent version of the Recommended Child and Adolescent Immunization Schedule for ages 18 years or younger or the Catch-up immunization schedule for persons aged four months-18 years who start late or who are more than one month behind, as published by the Centers for Disease Control and Prevention's Advisory Committee on Immunization Practices.
- Vaccine doses administered less than or equal to four days before the minimum interval or age are valid (grace period). Doses administered greater than or equal to five days earlier than the minimum interval or age are not valid doses and should be repeated when age appropriate.
- If MMR and varicella are **not** given on the same day, the doses must be separated by at least 28 days with no grace period.
- For additional information, please refer to the Ohio Revised Code 3313.67 and 3313.671 and the Ohio Department of Health (ODH) Director's Journal Entry regarding school immunization requirements, recommended vaccines, and exemptions to immunizations.
- **Please contact the Ohio Department of Health Immunization Program at 800-282-0546 or 614-466-4643 with questions.**

Ohio Department of Health

Last updated 01/2025.

Ohio School Immunization Requirement Details

DTaP **Diphtheria, Tetanus, Pertussis**	**Grades K-12** Four or more doses of DTaP or DT vaccine, or any combination. If all four doses were given before the fourth birthday, a fifth dose is required. If the fourth dose was administered at least six months after the third dose, and on or after the fourth birthday, a fifth dose is not required. *Recommended DTaP or DT minimum intervals for kindergarten students are four weeks between the first and second doses, and the second and third doses; and six months between the third and fourth doses and the fourth and fifth doses.*
Hep B **Hepatitis B**	**Grades K-12** Three doses of hepatitis B vaccine. The second dose must be administered at least 28 days after the first dose. The third dose must be given at least 16 weeks after the first dose and at least eight weeks after the second dose. The last dose in the series (third or fourth dose) must not be administered before age 24 weeks.
MMR **Measles, Mumps, Rubella**	**Grades K-12** Two doses of MMR vaccine. The first dose must be administered on or after the first birthday. The second dose must be administered at least 28 days after the first dose.
Polio	**Grades K-12** Three or more doses of IPV vaccine. The FINAL dose must be administered on or after the fourth birthday with at least six months between the final and previous dose, regardless of the number of previous doses. *If any combination of IPV and OPV was received, four doses of either vaccine are required. Only trivalent OPV (tOPV) counts toward the U.S. vaccination requirements. Doses of OPV administered before April 1, 2016, should be counted (unless specifically noted as administered during a campaign). Doses of OPV administered on or after April 1, 2016, should **not** be counted.*
Varicella **(Chickenpox)**	**Grades K-12** Two doses of varicella vaccine must be administered prior to entry. The first dose must be administered on or after the first birthday. The second dose should be administered at least three months after the first dose; however, if the second dose is administered at least 28 days after the first dose, it is considered valid.
Tdap **Tetanus, Diphtheria, Pertussis**	**Grades 7-12** One dose of Tdap vaccine must be administered on or after the tenth birthday. Tdap can be given regardless of the interval since the last tetanus or diphtheria-toxoid containing vaccine. *Children aged seven years or older with an incomplete history of DTaP should be given Tdap as the first dose in the catch-up series. If the series began at age seven to nine years, the fourth dose must be a Tdap given at age 11-12 years. If the third dose of Tdap is given at age 10 years, no additional dose is needed at age 11-12 years.*
Meningococcal **Meningococcal ACWY**	**Grades 7-11** One dose of meningococcal (serogroup A, C, W, and Y) vaccine must be administered on or after the 10th birthday. **Grade 12** Two doses of meningococcal (serogroup A, C, W, and Y) vaccine. Second dose on or after age 16 years. If the first dose was given on or after the 16th birthday, only one dose is required.

Ohio School Health History

To be used for Pre-and Elementary School

School _____

Enrolled _____

Child's Name	Gender	Age	Birthdate
	☐ Male ☐ Female		

Name of child's parent/legal guardian/s? _____

Parent/Guardian address _____

Home Phone number_____

Ethnicity

☐ Caucasian ☐ African American ☐ Hispanic ☐ Asian American ☐ Other

Social Service History

Mark the box if you have contact with any of the following agencies:

☐ Child/Protective Services If yes, Case worker's name _____

☐ Legal/Court System

☐ Family Counseling Services

☐ Mental Health Provider

☐ Other: _____

Mark the box if you or your child receive any of the following medical assistance:

☐ SSI, Disability ☐ Healthy Start ☐ Insurance (Blue Cross/Blue Shield, HMO)

☐ LEAP ☐ Medicaid/CHIP ☐ Other

Family History

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

Name	Birthdate	Gender	Health Concerns	Is the child in school?	If so, where?

Perinatal 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 the child was born? _____

What was the infant's birth weight? _____lbs. _____oz. ☐ Full term ☐ Early ☐ Late

Did the infant have any sickness or problems? ☐ Yes ☐ No

If yes, explain briefly_____

Developmental 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 his/her siblings or playmates?

□ About the same □ Delayed □Advanced

Allergies

Please list and describe allergies and reactions

Medications/Drugs
Foods/plants/animals/other
Recommended treatment if allergy is severe

Injuries, Illnesses and Hospitalizations

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

Injuries/Illness/Hospitalizations	Age	If hospitalized, please explain

Does your child always wear a seatbelt while riding in automobiles? □ Yes □ No

Does the student wear a helmet when bicycling, skating/rollerblading or riding a motorcycle? □ Yes □ No

Medication Information

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

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

Health Conditions

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

- ☐ Abnormal spinal curvature (Scoliosis)
- ☐ Allergies/hayfever
- ☐ 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
- ☐ Concern about relation with siblings or friends
- ☐ Cystic Fibrosis
- ☐ Diabetes
- ☐ Eczema/Chronic skin conditions
- ☐ 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

Behavioral History

The child is usually: ☐ very active ☐ normally active ☐ rather inactive

Has your child ever been violent or acted out in the following manner towards adults or children:

☐ hitting ☐ kicking ☐ biting ☐ fighting ☐ scratching

Do you have any concern about how your child gets along with other children?

_____

_____

Please add any comments or concerns you have about your child's health, development, behavior, family or home life that you would like the school to be aware of.

_____

_____

Is the student enrolled in a special education course? ☐ Yes ☐ No

If yes, please list _____

_____ _____

Parent/Guardian Signature Date

Instructions for the following Health forms:

1. Please take pages 4 and 5 (Physical Assessment) with you to your physician at the time of your child's physical. This physical form must be returned to Perry Elementary School's office prior to the first day of school.

2. Please take page 6 (Oral Assessment) to your dentist when your child has his/her yearly check-up and cleaning. This is optional, but highly recommended.

3. A green Request to Administer Medications form must be complete for ALL medications given at school. This includes over-the-counter medications (Tylenol, Advil, Benadryl and Tums, etc.)

    a.) If you feel your child will need to visit the clinic for Tylenol, Advil, Benadryl Tums during the course of the school year, please complete **both sides,** excluding the prescriber signature box, of the attached form (Request to Administer Medications). You are welcome to drop off a supply of over-the-counter medications to the clinic for the entire year with the completed form.

    b.) If your child will need prescription medication, please complete the **front and back** of the Request to Administer Medications form along with the **required prescriber's signature.**

All medications must be in the original container and be delivered by an adult to the school nurse.

If you have any questions, please contact the district nurse at 259-9600 x9671 or x9672.

Healthy Regards,

Susie McKoon, RN

Ohio School Health History

Physical Assessment

School _____

Enrolled _____

Child's Name	Gender	Age	Birthdate
	☐ Male ☐ Female		
Ethnicity ☐ Caucasian ☐ African American ☐ Hispanic ☐ Asian American ☐ Other			

Objective Data

Height	Weight	B.P.

Immunizations

Type	Date Mo/Day/Yr					
DTaP DPT or DT						5th dose required if 4th dose given before age 4
DT/Td						
POLIO					4 doses any combination, final dose must be given on or after 4th birthday	
MMR				2 doses required for K		
HEPATITIS B				3 doses required for K		
VARICELLA			2 doses required for K			
HIB (prior to age 5 only)					0-14 months; 3-4 doses 15-59 months: 1 dose	
TUBERCULIN TEST						
ROTAVIRUS (given @ 2-4-6 mo, not after 12 months)						
OTHER						

Screening Tests

Vision Date	**Hearing** Date
Distance Acuity Right_____ Left_____	Pure tone testing:
Muscle Balance ☐Pass ☐Fail ☐Not Done	Right ear ☐Pass ☐Fail ☐Not Done
Farsightedness ☐Pass ☐Fail ☐Not Done	Left ear ☐Pass ☐Fail ☐Not Done
Color ☐Pass ☐Fail ☐Not Done	Child wears hearing aid? ☐Yes ☐No
Child wears glasses? ☐Yes ☐No	Testing with hearing aid? ☐Yes ☐No
Tested with glasses? ☐Yes ☐No	Referral made? ☐Yes ☐No
Referral made? ☐Yes ☐No	Other test (specify) _____
Specify Test/Equipment	

Speech Assessment Date
☐ Child has no discernible speech problem
☐ Child has possible problem with: ☐ Articulation ☐ Rhythm ☐ Voice ☐Language
Speech evaluation is recommended: ☐Yes ☐ No

Laboratory Tests

☐Hemoglobin/Hematocrit ☐Urine Protein ☐Urine blood ☐Urine glucose
☐Other _____

Physical Examination

Date of Examination:_____

☐ This child is essentially within normal limits.

☐ This child is not within normal limits.
Explain:

Does this child have any physical, developmental or behavioral problems? Suggest special programs, placement or attention that the school can provide.

Activities & Limitations
Can the child participate fully in the following activities:

Classroom and academic activities	☐Yes	☐No
Physical education classes	☐Yes	☐No
Competitive athletics	☐Yes	☐No
Contact and collision sports	☐Yes	☐No

Specify any limitations:

Is this child on any medications? ☐Yes ☐No
Explain:

Examiner's Signature _____ Date Signed_____

Examiner's Printed Name _____

Address _____
_____

Phone _____

Ohio School Health History

Oral Assessment

School _____

Enrolled _____

Child's Name	Gender	Age	Birthdate
	☐ Male ☐ Female		

The following services have been performed:

☐ Examination by dentist
☐ Dental sealants
☐ Oral Prophylaxis (cleaning)
☐ Orthodontic assessment
☐ Radiographs
☐ Diagnosis
☐ Oral screening
☐ Fluoride Application
☐ Prescription for fluoride supplements

The following oral hygiene instruction was provided:

☐ Toothbrushing
☐ Flossing
☐ Diet counseling related to dental health
☐ Home/school use of fluoride mouth rinse

The following statements are applicable:

- ☐ No apparent care needed at this time.
- ☐ All necessary preventive services have been performed. (Fluoride treatment, prophylaxis)
- ☐ No restorative services are required at this time.
- ☐ Further treatment is indicated. (See comments)
- ☐ Further appointments have been arranged. (ex. Orthodontic, restorative)

Comments:

Examiner's Signature _____ Date Signed_____

Examiner's Printed Name _____

Address _____

_____

Phone _____