

Canal Winchester Local School District Health History

Student's full name	Sex <input type="checkbox"/> Female <input type="checkbox"/> Male	Date of birth / /
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Family Health History Please list anyone living with child. List allergies, heart problems, diabetes, cancer or other serious health conditions

Family Member	Age	Medical Conditions
Father		
Mother		
Other		
Brothers and Sisters		

Birth and Developmental History No unusual birth or developmental history

Did the mother have any unusual physical or emotional illness during this pregnancy? <input type="checkbox"/> Yes <input type="checkbox"/> No
Was the baby born full term? <input type="checkbox"/> Yes <input type="checkbox"/> No Did the infant have any sickness or problems? <input type="checkbox"/> Yes <input type="checkbox"/> No
Briefly explain illness or problem
How does the child's development compare to other children, such as his or her brothers/sisters or playmates? <input type="checkbox"/> About the same <input type="checkbox"/> Delayed <input type="checkbox"/> Advanced

Student Health Conditions

<input type="checkbox"/> Yes , my child receives regular medical/health care for the following:	<input type="checkbox"/> No medical conditions																																	
<table style="width: 100%; border: none;"> <tr> <td style="width: 33%;"><input type="checkbox"/> Allergies</td> <td style="width: 33%;"><input type="checkbox"/> Diabetes</td> <td style="width: 33%;"><input type="checkbox"/> Seizure disorder</td> </tr> <tr> <td><input type="checkbox"/> Asthma</td> <td><input type="checkbox"/> Depression</td> <td><input type="checkbox"/> Sickle cell anemia</td> </tr> <tr> <td><input type="checkbox"/> ADD/ADHD</td> <td><input type="checkbox"/> Ear problem/hearing difficulty</td> <td><input type="checkbox"/> Skin conditions</td> </tr> <tr> <td><input type="checkbox"/> Autism</td> <td><input type="checkbox"/> Emotional concerns</td> <td><input type="checkbox"/> Speech problems</td> </tr> <tr> <td><input type="checkbox"/> Behavior Concerns</td> <td><input type="checkbox"/> Headaches</td> <td><input type="checkbox"/> Traumatic brain injury</td> </tr> <tr> <td><input type="checkbox"/> Birth/Congenital Malformations</td> <td><input type="checkbox"/> Heart problems</td> <td><input type="checkbox"/> Vision problems (glasses, contacts)</td> </tr> <tr> <td><input type="checkbox"/> Bone/muscle/joint problems</td> <td><input type="checkbox"/> Hemophilia</td> <td><input type="checkbox"/> Other _____</td> </tr> <tr> <td><input type="checkbox"/> Blood problems</td> <td><input type="checkbox"/> Juvenile arthritis</td> <td><input type="checkbox"/> Other _____</td> </tr> <tr> <td><input type="checkbox"/> Bowel/bladder problems</td> <td><input type="checkbox"/> Lead poisoning</td> <td><input type="checkbox"/> Other _____</td> </tr> <tr> <td><input type="checkbox"/> Cancer</td> <td><input type="checkbox"/> Migraines</td> <td><input type="checkbox"/> Other _____</td> </tr> <tr> <td><input type="checkbox"/> Cystic fibrosis</td> <td><input type="checkbox"/> Neuromuscular disorder</td> <td><input type="checkbox"/> Other _____</td> </tr> </table>	<input type="checkbox"/> Allergies	<input type="checkbox"/> Diabetes	<input type="checkbox"/> Seizure disorder	<input type="checkbox"/> Asthma	<input type="checkbox"/> Depression	<input type="checkbox"/> Sickle cell anemia	<input type="checkbox"/> ADD/ADHD	<input type="checkbox"/> Ear problem/hearing difficulty	<input type="checkbox"/> Skin conditions	<input type="checkbox"/> Autism	<input type="checkbox"/> Emotional concerns	<input type="checkbox"/> Speech problems	<input type="checkbox"/> Behavior Concerns	<input type="checkbox"/> Headaches	<input type="checkbox"/> Traumatic brain injury	<input type="checkbox"/> Birth/Congenital Malformations	<input type="checkbox"/> Heart problems	<input type="checkbox"/> Vision problems (glasses, contacts)	<input type="checkbox"/> Bone/muscle/joint problems	<input type="checkbox"/> Hemophilia	<input type="checkbox"/> Other _____	<input type="checkbox"/> Blood problems	<input type="checkbox"/> Juvenile arthritis	<input type="checkbox"/> Other _____	<input type="checkbox"/> Bowel/bladder problems	<input type="checkbox"/> Lead poisoning	<input type="checkbox"/> Other _____	<input type="checkbox"/> Cancer	<input type="checkbox"/> Migraines	<input type="checkbox"/> Other _____	<input type="checkbox"/> Cystic fibrosis	<input type="checkbox"/> Neuromuscular disorder	<input type="checkbox"/> Other _____	
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Please explain any conditions above or any reasons for hospitalizations.																																		

Is your child lactose intolerant? Yes No

A physician's note is required to receive an alternative to milk in the cafeteria.

Health History continued

Please indicate any allergies your child may have.		
Allergy Type	Reaction	Epi-Pen
<input type="checkbox"/> Bee/Insect		<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Food _____ _____		<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Medication _____		<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Other _____		<input type="checkbox"/> Yes <input type="checkbox"/> No

Please list any prescription and over-the-counter medication that your child takes on a regular basis			
Medication	Dose	Time	Reason
Prescription medication required during school? <input type="checkbox"/> Yes <input type="checkbox"/> No The <u>Medication and Treatment Authorization</u> form must be completed by physician and parent if your child requires medication during school. All medication must be provided in the original bottle or package and will be stored in the clinic.			
Over-the-counter medication needed during school? <input type="checkbox"/> Yes <input type="checkbox"/> No The <u>Over-the-counter Medication Authorization</u> form must be completed by parent if your child might require over-the-counter medication during school. This includes cough drops, cortisone cream, eye wetting drops, Benadryl, etc. All medication must be provided by the parent in the original bottle or package and will be stored in the clinic.			

Does your child require any special procedures and/or treatments for their health condition? <input type="checkbox"/> Yes <input type="checkbox"/> No If YES, please explain.
The <u>Medication and Treatment Authorization</u> form must be completed by physician and parent if your child requires special procedures and/or treatments during school.

Please indicate any other information about your child's health or development that you think would be helpful for the school to know.

Form completed by	Relationship to student	Date / /