MV City Schools School Health Record

School_____ Grade_____

Date Enrolled_____

***To be completed by parent only. Use back of page for additional space, if needed.**

Child's Name	Birth date	Parent/Guardian Name	Home Phone Number

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:

What is 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/her brothers/sisters or playmates?

About the same_____ delayed_____ advanced_____

Health Conditions: Please check any/all that this child has had: ◯ Not Applicable

❑ 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

Injuries, Illnesses & Hospitalizations: Please explain.

Current Health and existing conditions:

Does your child need special assistance at school?

Is your child enrolled in a special education class? _□_Yes _□_No

Allergies:	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 available at the school clinic or district website: www.revereschools.org.

Family Medical History List family members, relationship to student, birth date and significant health concerns.

Name	Relationship	Birth date	Health Concern
1.			
2.			
3.			
4.			

MV City Schools **School Health Record** School: _____

Physician's Report

***School Nurse must have on file within 30 days of starting school.**

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 C. Competitive athletics? □ yes □ no

B. Physical education classes? □ 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?

_____

_____

_____

MV City Schools **School Health Record**

Medications:

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

Immunizations:

Ohio Law describes minimum requirements for school entrance.
Separate print-out from doctor's office with the needed information is acceptable.
Please staple to back of this form.

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.

Other_____ _____

Please print or stamp (Required):

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

MV City Schools **Dentist Report/School Health Record**

School:_____

***School Nurse must have on file within 30 days of beginning 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	