Southeastern Local Schools District

Student Health History Form

- Form must be completed and signed by parent at registration before student starts school
- Form must be filed in student's health record at the assigned school building

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Student's name:_____ Date of Birth:_____

Grade:_____ Male:_____ Female:_____

Student's Address:_____

_____

Parent/Guardian Names/ Emergency Contact

1. Name:_____ Phone:_____
2. Name:_____ Phone:_____
3. Name:_____ Phone:_____

Medications taken at home:

Name:_____ Dosage:_____ Reason:_____

Name:_____ Dosage:_____ Reason:_____

Name:_____ Dosage:_____ Reason:_____

- If you need additional space attach a sheet to this form.

HEALTH HISTORY (Please check all conditions your child has or has had, and explain below)

- ☐ ADD/ADHD
- ☐ Arthritis/joints
- ☐ Asthma
- ☐ Birth defects
- ☐ Blood disorder
- ☐ Bowel problems
- ☐ Cancer
- ☐ Developmental delays
- ☐ Diabetes
- ☐ Hearing problems
- ☐ Heart problems
- ☐ Hepatitis
- ☐ Hospitalizations
- ☐ Learning problems
- ☐ Menstrual problems
- ☐ Mental health issues
- ☐ Migraines
- ☐ Physical limitations
- ☐ Relationship issues
- ☐ Seizures, tics or tremors
- ☐ Serious illnesses
- ☐ Skin problems
- ☐ Stomach problems
- ☐ Surgeries
- ☐ Urinary problems
- ☐ Visual problems
- ☐ Other

Behavioral Issues: _____

_____

Allergies: Type: Reaction Treatment

_____

_____

_____

_____

Dietary: Does your child have any dietary restrictions? _____

SPEECH AND LANGUAGE DEVELOPMENT

Are you concerned your child may have or has had a problem with speech or language development? _____

What are your concerns? _____

Any past speech therapy? _____ **Where and when?** _____

OTHER CONCERNS

Please share other information or concerns about your child's emotional, physical, or developmental growth.

_____

_____

Please share any family circumstances or behavioral concerns you have about your child.

_____

_____

Is your child on an IEP or 504 Plan ☐ **yes** ☐ **no**

Please contact the Ohio Benefits website @ www.ohiomh.com or call 800-324-8680 to see if you may be eligible for individual, family, or student Medicaid or Medicare insurance.

Check if you would like a conference with the school nurse. ☐

Parent/Guardian Printed name: _____ **Relationship:** _____

Parent/Guardian Signature: _____ **Date:** _____

Physicians Name: _____

Phone: _____

Psychiatrist Name: _____

Phone: