KENT CITY SCHOOLS
KENT, OHIO

HEALTH INFORMATION FOR ALL CHILDREN ENTERING SCHOOL

Children must be healthy and practice good health habits involving nutrition, adequate rest, and exercise in order to be able to attend school regularly and take full advantage of the educational programs offered them.

Children entering school for the first time should be examined by their physician and dentist. Please have your child's physician complete pages 1 and 2 (Physical Assessment) and your child's dentist complete page 3 (Oral Assessment). If health problems do exist, the school should know about them so that adaptations can be made in order to provide the best educational experience for your child.

OHIO LAW REQUIRES THAT YOUR CHILD HAVE THE IMMUNIZATIONS LISTED ON THE BACK BEFORE ENTERING SCHOOL.

NOTE:

If your child does not have the required number of doses of vaccine, please arrange to have the immunizations completed by your physician, local clinic, Portage County Child Health Services (330-297-5437), or health department before school begins.

Should you have any health concerns or questions, please feel free to contact Vicki Nichols, our elementary school nurse, between the hours of 8:10 a.m. and 3:40 p.m. Monday through Friday. Her schedule is as follows:

Monday – Franklin School, 330-676-8450
Tuesday – Walls School, 330-676-8300
Wednesday – Holden School, 330-676-8400
Thursday – Longcoy School, 330-676-8350
Friday – Davey School, 330-676-7400

We look forward to your child attending the Kent City Schools.

Ohio School Health History
Health History – To be completed by parent/guardian (p. 1 and 2)

School D F H L W Date Enrolled ______________________

Child's Name	☐ Male ☐ Female	Age	Date of Birth

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 receives any of the following medical assistance:
- ☐ SSI, Disability ☐ Healthy Start ☐ Insurance (Blue Cross/Blue Shield, HMO)
- ☐ LEAP ☐ Medicaid/CHIP ☐ Other: ______________________

Family History
Please list first and last name of the family members with whom the child lives including parents and siblings.

Name	Date of Birth	Gender	Health Concerns	Child in school?	If so, where?
1.					
2.					
3.					
4.					
5.					

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?
Was the infant born: ☐ Full term ☐ Early ☐ Late What was the infant's birth weight? ____Lbs. ____Oz.

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

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 or her brothers/sisters or playmates?

☐ About the same ☐ Delayed ☐ Advanced

Allergies
Please list and describe allergies or allergic reactions.

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

Injuries, Illnesses & Hospitalizations

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

Injuries/Illness/Hospitalizations	Age	If hospitalized, please explain.

Medication Information

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

Name of Medication	What is the medication take 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

Do you have any concerns about how your child gets along with other children? ☐ Yes ☐ No If yes, explain. ___________________

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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. ____

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Ohio School Health History

Physical Assessment – To be completed by physician (p. 1, 2)

School D F H L W   Date Enrolled ________________

Child's Name	☐ Male ☐ Female	Age	Date of Birth

Objective Data

Height: _________ Weight: ____________ B.P.: _________________

IMMUNIZATION – shaded areas required for school entry					
Type	**DATE – Month/Day/Year**				
MMR				2nd dose required for K 2nd dose required for grade 7-12	
POLIO				4th dose required if 3rd dose given before age 4	
HEPATITIS B					
DtaP DPT or DT					5th dose required if 4th dose given before age 4
DT/Td					
VARICELLA					
HIB (prior to age 5 only)				0-14 months; 3-4 doses 15-59 months: 1 dose	
TUBERCULIN TEST					
ROTAVIRUS (given @ 2-4-6 months, 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 aide?		☐ Yes	☐ No
Child wears glasses?		☐ Yes	☐ No	Testing with hearing aide?		☐ Yes	☐ No
Tested with glasses?		☐ Yes	☐ No	Referral made?		☐ Yes	☐ No
Referral made?		☐ Yes	☐ No				
Specify Test/Equipment ______________________				Other test (specify) _______________________			

Speech Assessment

Date _______________

☐ Child has no dissemble 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:

Please describe any physical, developmental or behavioral problems.

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 & 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 – To be completed by dentist (p. 3)

School D F H L W Date Enrolled ________________

Child's Name	☐ Male ☐ Female	Age	Date of Birth

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 mouthrinse

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 ____