Akron Children's Hospital
School Health Services

Wooster City School District
Inspiring World-Class Academic Achievement

School Health History Record/Update
School Year: _____

Student Name: _____ **Male** _____ **Female** _____

Date of birth: _____ **Grade**: _____

Developmental History: *Please give the approximate age when your child:*

Walked alone _____ Spoke in sentences _____ Was toilet trained _____ Dressed self _____

How does this child's development compare to other children, such as brothers/sisters or playmates?
About the same _____ Delayed _____ Advanced _____

Health Conditions: *Please check any that your child has or did have:*

- ❒ Allergies
- ❒ Anaphylactic reaction
- ❒ Asthma or wheezing
- ❒ ADD/ADHD
- ❒ Autism
- ❒ Behavior/Emotional concerns
- ❒ Birth/Congenital malformations
- ❒ Blood problems
- ❒ Bone/muscle/joint problems
- ❒ Bowel/bladder problems
- ❒ Cancer
- ❒ Chickenpox
- ❒ Cystic fibrosis
- ❒ Diabetes
- ❒ Depression
- ❒ Ear problem/hearing difficulty
- ❒ Eczema/skin conditions
- ❒ Headaches (frequent)
- ❒ Heart Disease
- ❒ Hepatitis
- ❒ Juvenile arthritis
- ❒ Lead poisoning
- ❒ Meningitis/Encephalitis
- ❒ Neuromuscular disorder
- ❒ Seizures/Epilepsy
- ❒ Sickle cell anemia
- ❒ Sore throat (frequent)
- ❒ Speech difficulties
- ❒ Toothaches/dental problems
- ❒ Urinary tract infections
- ❒ Vision problems (glasses, contacts)
- ❒ Wetting during day or night
- ❒ Other_____

Illness, Injuries & Hospitalizations (please explain):

_____

_____

_____

Medical Home: *Please provide us with your child's current health care provider's name and contact information*

Physician Name: _____

Address: _____

Phone: _____

- Please continue on the back -

Current Health: *Tell us about any current health conditions or concerns:*

_____

_____

_____

Student Name: _____

Allergies: If your child has any food or environmental allergies, please obtain the Allergy Action Plan form from the school clinic for your child's health record.

Allergy	Reaction	Treatment

Medications: Describe medicine your child takes regularly. If your child must take medication at school, please obtain the Medication Administration Authorization form from the school clinic to be completed by you and your child's doctor.

Medication	Reason	How often?	What time?

Explain any special assistance your child may need during the school day:

_____

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:

_____

If you have questions or concerns about your child's health or would like information about a medical home for your child or community services that may be available, please contact your school clinic.

_____ _____ _____

Signature of person completing form Relationship to child Date