MV City Schools — School Health Record

School________________ Grade______________

Fcvg"Gptqnngf ___________

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

Distance Acuity right _______ left _______
Tested with glasses? □ yes □ no
Muscle Balance □ pass □ fail □ not done
Farsightedness □ pass □ fail □ not done
Random Dot E □ pass □ fail □ not done
Color vision with pseudo-isochromic plates
□ pass □ fail □ not done
Child wears glasses? □ yes □ no
Glasses worn for: □ distance □ reading □ at all times
Referral made? □ yes □ no

HEARING Date

Pure tone testing (20 dB @ 1000, 2000, 4000 Hz)

Right ear □ pass □ fail □ not done
Left ear □ pass □ fail □ not done
Other tests (specify) ______________________________

Child wears hearing aid? □ yes □ no
Tested with Hearing aid? □ 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	