First time enrolling in CCS ☐yes ☐no Lottery / Lottery Only / IOE / PreK

School:__________________________ **Year:**_____ ID#_______________

Student Name:____

Date of Birth:_________________ **Male/Female/ Other:**__________
Month / Day / Year

Parent/Guardian Phone Number:________________________________

Enrollment Health Questions

Columbus City Schools
Health, Family and Community Services
430 Cleveland Ave.
Columbus Ohio 43215

* Please meet with the nurse at the school if the student has health needs. *

check yes or no, if yes - please complete the section related to the response

Section	Question	Yes	No
TB	Was the student born **OUTSIDE** of the US? If yes, in what country? _______________________	☐ yes	☐ no
	Has the student been in the US for ≥ 5 years	☐ yes	☐ no
	Has the student traveled outside of the US for ≥ 60 consecutive days? If yes, to what country?_______________________	☐ yes	☐ no
Development	Any health problems during the pregnancy or birth of this child? **Birth weight:** __________	☐ yes	☐ no
	Was the child born premature (early)? How many weeks? _______ Newborn health problems: ______________________________	☐ yes	☐ no
	Does this child have development delays? Current problems with: ☐ Sitting up ☐ Walking ☐ Toilet training ☐ Speaking Other problems or concerns: ______________________________	☐ yes	☐ no
Allergies	Medicine allergy____________________ Describe reaction ___________________________	☐ yes	☐ no
	Food allergy______________________ Describe reaction ___________________________	☐ yes	☐ no
	Bee/Wasp allergy__________________ Describe reaction ___________________________	☐ yes	☐ no
	Other:___________________________ Describe reaction ___________________________	☐ yes	☐ no
	Will this child need an **Epi-pen** or other allergy medicine at school ?	☐ yes	☐ no
Health Conditions	Check all that apply to this child: ☐ Asthma ☐ Behavior concerns ☐ Hearing problems:________________ ☐ ADHD/ ADD ☐ Seizures or epilepsy ☐ tubes in ears ☐ hearing device ☐ Diabetes ☐ Heart problems ☐ Vision problems: _________________ ☐ Headaches ☐ Sickle cell: ☐disease / ☐trait ☐ Learning difficulties, describe:______________________________ ☐ Mental health concerns, depression, anxiety: ______________________________ ☐ Other: ______________________________	Has health conditions: ☐ yes	☐ no
Meds	Does this child take medications at home every day?	☐ yes	☐ no
	Will this child need medications **at school**? *Please list the medications at the bottom of the form.*	☐ yes	☐ no
Health History	Has this child ever had Chickenpox? ☐ **yes – Date:**_____________		☐ no
	Has this child ever had surgery? Explain:______________________________	☐ yes	☐ no
	Has this child been to the hospital or gone unconscious after a head injury or concussion?	☐ yes	☐ no
	Does this child need a special diet? If yes, what kind?______________________________	☐ yes	☐ no
	Does this child use **glasses**, hearing aids, walker, leg braces, wheelchair, catheter, feeding tube, or other adaptive devices? (Please circle which ones)	☐ yes	☐ no

Please add details from above, medications, or other concerns about this child's health, development, behavior, family or home life:

If you would like assistance finding a health or dental clinic please see the nurse at your child's school.

Completed by____________________________ Relationship to Student______________________ Date_______________

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