COLUMBUS CITY SCHOOLS

First time enrolling in CCS ☐yes ☐no Type of Enrollment: Regular Enrollme

School:_____ **Year:**_____ ID#_____

Student Name:_____

Date of Birth:_____ **Gender:** 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

TB

Was the student born **OUTSIDE** of the US? If yes, in what country? _____ ☐yes ☐no

Has the student been in the US for less than 5 years? ☐yes ☐no

Has the student traveled outside of the US for 30 or more consecutive days? ☐yes ☐no

If yes, to what country? _____

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? _____ ☐yes ☐no

Newborn health problems: _____

Does this child have development delays? ☐yes ☐no

Current problems with: ☐ Sitting up ☐ Walking ☐ Toilet training ☐ Speaking

Other problems or concerns: _____

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**? ☐yes ☐no

Please list the medications at the bottom of the form.

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 indicate 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_____

