



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

TB		Was the student born OUTSIDE of the US? If yes, in what country? _____	<input type="checkbox"/> yes	<input type="checkbox"/> no
		Has the student been in the US for less than 5 years?	<input type="checkbox"/> yes	<input type="checkbox"/> no
		Has the student traveled outside of the US for 30 or more consecutive days?	<input type="checkbox"/> yes	<input type="checkbox"/> no
		If yes, to what country? _____		
Development	Any health problems during the pregnancy or birth of this child? Birth weight: _____		<input type="checkbox"/> yes	<input type="checkbox"/> no
	Was the child born premature (early)? How many weeks? _____		<input type="checkbox"/> yes	<input type="checkbox"/> no
	Newborn health problems: _____			
Allergies	Does this child have development delays? Current problems with: <input type="checkbox"/> Sitting up <input type="checkbox"/> Walking <input type="checkbox"/> Toilet training <input type="checkbox"/> Speaking Other problems or concerns: _____		<input type="checkbox"/> yes	<input type="checkbox"/> no
	Medicine allergy _____ Describe reaction _____		<input type="checkbox"/> yes	<input type="checkbox"/> no
		Food allergy _____ Describe reaction _____	<input type="checkbox"/> yes	<input type="checkbox"/> no
		Bee/Wasp allergy _____ Describe reaction _____	<input type="checkbox"/> yes	<input type="checkbox"/> no
		Other: _____ Describe reaction _____	<input type="checkbox"/> yes	<input type="checkbox"/> no
		Will this child need an Epi-pen or other allergy medicine at school ?	<input type="checkbox"/> yes	<input type="checkbox"/> no
Health Conditions	Check all that apply to this child:		<div style="border: 1px solid black; padding: 5px;"> Has health conditions: </div> <input type="checkbox"/> yes <input type="checkbox"/> no	
	<input type="checkbox"/> Asthma <input type="checkbox"/> Behavior concerns <input type="checkbox"/> Hearing problems: _____			
	<input type="checkbox"/> ADHD/ ADD <input type="checkbox"/> Seizures or epilepsy <input type="checkbox"/> tubes in ears <input type="checkbox"/> hearing device			
	<input type="checkbox"/> Diabetes <input type="checkbox"/> Heart problems <input type="checkbox"/> Vision problems: _____			
	<input type="checkbox"/> Headaches <input type="checkbox"/> Sickle cell: <input type="checkbox"/> disease / <input type="checkbox"/> trait			
	<input type="checkbox"/> Learning difficulties, describe: _____			
	<input type="checkbox"/> Mental health concerns, depression, anxiety: _____			
<input type="checkbox"/> Other: _____				
Meds	Does this child take medications at home every day?		<input type="checkbox"/> yes	<input type="checkbox"/> no
	Will this child need medications at school ? Please list the medications at the bottom of the form.		<input type="checkbox"/> yes	<input type="checkbox"/> no
Health History	Has this child ever had Chickenpox? <input type="checkbox"/> yes – Date: _____		<input type="checkbox"/> yes	<input type="checkbox"/> no
	Has this child ever had surgery? Explain: _____		<input type="checkbox"/> yes	<input type="checkbox"/> no
	Has this child been to the hospital or gone unconscious after a head injury or concussion?		<input type="checkbox"/> yes	<input type="checkbox"/> no
	Does this child need a special diet? If yes, what kind? _____		<input type="checkbox"/> yes	<input type="checkbox"/> no
	Does this child use glasses , hearing aids, walker, leg braces, wheelchair, catheter, feeding tube, or other adaptive devices? (Please circle which ones)		<input type="checkbox"/> yes	<input type="checkbox"/> 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 _____