Office use:_____ ☐Lottery ☐PS ☐KG ☐ES ☐MS ☐HS SN_____ ☐15-16 ☐16-17

Student Name_____

Gender M F **Date of Birth**_____
Month / Day / Year

Parent/Guardian Phone_____

Enrollment Health Questions

Columbus City Schools
Health, Family and Community Services
61 South 6th Street, Columbus Ohio 43215

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

	Did you bring this child's **up-to-date** vaccine record? *Vaccine records are due to the school nurse by 14 days after enrollment to stay in school.* ☐ *referred for vaccines* ☐ *exclude on 15th day*	☐ no	☐ yes
	Was this child born outside the US, or ever traveled outside the US for more than one month?	☐ yes	☐ no
Birth	Any health problems during the pregnancy or birth of this child? **Birth weight:** _____	☐ yes	☐ no
Birth	Did the birth come very early or late? How many weeks? _____ Newborn health problems: ☐ yellow jaundice ☐ blue spells ☐ convulsions ☐ other_____	☐ early ☐ late	☐ on time
Development	How does this child's development compare to other children, such as brothers, sisters? Delayed or problems with: ☐ Sitting up alone ☐ Walking ☐ Toilet training ☐ Speaking Other problems or delays with growth and abilities_____ Which hand does this child prefer to write with? ☐ Left ☐ Right ☐ Both	☐ slower	☐ faster ☐ the same
Allergies	Medicine allergy_____ Describe reaction _____	☐ yes	☐ no
Allergies	Food allergy_____ _____ Describe reaction _____	☐ yes	☐ no
Allergies	Bee/Wasp allergy_____ Describe reaction _____	☐ yes	☐ no
Allergies	Will this child need an **Epi-pen** or other allergy medicine at school ?	☐ yes	☐ no
Health Conditions	Does the child have any of these conditions? (please mark) ☐ Diabetes ☐ Behavior concerns ☐ Mental health concerns, depression, ODD ☐ Asthma ☐ Headaches often ☐ Poor hearing/sight, ear or eye problems ☐ Seizures or epilepsy ☐ Heart problems ☐ Ear infections often or ☐ tubes in ears ☐ Sickle cell: ☐disease ☐trait ☐ Learning difficulties like ADHD, ADD, dyslexia ☐ Other: _____	☐ yes	☐ no
Medicine	Does this child take medications at home every day? *Please list the medications at the bottom of the form.*	☐ yes	☐ no
Medicine	Does this child take medications often, but not every day?	☐ yes	☐ no
Medicine	Will this child need medications **at school**?	☐ yes	☐ no
Health History	Has this child ever had Chickenpox? ☐ yes - What year?_____		☐ no
Health History	Has this child ever had to stay in the hospital overnight?_____	☐ yes	☐ no
Health History	Has this child ever had surgery? Explain:_____	☐ yes	☐ no
Health History	Has this child been to the hospital or gone unconscious after a head injury or concussion?	☐ yes	☐ no
Health History	Does this child need a special diet? If yes, what kind?_____	☐ yes	☐ no
Health History	Is there any activity this child must avoid? (Will need doctor's order for restriction.)	☐ yes	☐ no
Health History	Does this child use **glasses**, hearing aids, walker, leg braces, wheelchair, catheter, feeding tube, or other adaptive devices? (Please circle which one.)	☐ yes	☐ no
	Do you need help finding a medical clinic, dental clinic, or health insurance?	☐ yes	☐ no

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

Completed by_____ Relationship to Student_____ Date_____

o uploaded
o Packet given