

**St. Gregory the Great 2008-2009 School Year  
Ohio Department of Health \* School and Adolescent Health  
HEALTH HISTORY**

\_\_\_\_\_ Male \_\_\_\_\_ Female \_\_\_\_\_  
Student's Name Birth date

**Family Health History:** Please list allergies, heart problems, diabetes, cancer or other serious health conditions.

Father
Mother
Brothers/sisters

Birth and Developmental History \_\_\_\_\_ no unusual birth or developmental history  
Did mother have any unusual physical or emotional illness during the pregnancy \_\_\_ Yes \_\_\_ No  
Infant born full term? \_\_\_ Yes \_\_\_ No Infant have any sickness or problems? \_\_\_ Yes \_\_\_ No  
Briefly explain illness or problems \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

How does the child's development compare to other children, such as his or her brothers, sisters or playmates? \_\_\_\_\_ About the same \_\_\_\_\_ Delayed \_\_\_\_\_ Advanced

**Student Health Conditions**

\_\_\_\_\_ Yes, my child receives regular medical/health care for the following conditions  
\_\_\_\_\_ No medical conditions

- |                                      |                                      |                                     |
|--------------------------------------|--------------------------------------|-------------------------------------|
| _____ Allergies                      | _____ Diabetes                       | _____ Seizure disorder              |
| _____ Asthma                         | _____ Depression                     | _____ Sickle cell anemia            |
| _____ ADD/ADHD                       | _____ Ear problem/hearing difficulty | _____ Skin conditions               |
| _____ Autism                         | _____ Emotional concerns             | _____ Speech problems               |
| _____ Behavior concerns              | _____ Headaches                      | _____ Traumatic brain injury        |
| _____ Birth/congenital malformations | _____ Heart Problems                 | _____ Vision problems(glasses, etc) |
| _____ Bone/muscle/joint problems     | _____ Hemophilia                     | Other _____                         |
| _____ Blood problems                 | _____ Juvenile arthritis             | Other _____                         |
| _____ Bowel/bladder problems         | _____ Lead poisoning                 | Other _____                         |
| _____ Cancer                         | _____ Migraines                      | Other _____                         |
| _____ Cystic fibrosis                | _____ Neuromuscular disorder         | Other _____                         |

Please explain any conditions above or any reasons for hospitalization: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Please indicate any allergies you child may have

Allergy type	Reaction	School restrictions/actions
Bee/Insect		
Food		
Medication		
Other		

Medication and dose	Time	Reason

Do any health and/or medical conditions require school restrictions, modifications, and/or intervention?  Yes  No

If yes explain \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

Please indicate any other information about your child's health or development that you think would be helpful for the school to know.

\_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

Form completed by \_\_\_\_\_

Relationship to student \_\_\_\_\_

Date \_\_\_\_\_