Akron Children's Hospital
School Health Services

School Health History Record/Update
School Year: _____

**Student Name**: _____ **Male** _____ **Female** _____

**Date of birth: _____** **Grade: _____**

## Developmental History: Please give the approximate age when your child:

Walked alone_____ Spoke in sentences_____ Was toilet trained _____ Dressed self_____

How does this child's development compare to other children, such as brothers/sisters or playmates?
About the same_____ Delayed_____ Advanced_____

## Health Conditions: Please check any that your child has or had

_____Allergies
_____Anaphylactic reaction
_____Asthma or wheezing
_____Attention Deficit Disorder
_____Behavior/Emotional concerns
_____Birth/Congenital malformations
_____Blood problems
_____Bone/Joint problems
_____Bowel problems
_____Cancer
_____Chickenpox
_____Cystic Fibrosis
_____Diabetes
_____Ear problems/poor hearing
_____Eczema/skin conditions
_____Eye problems/poor vision
_____Headache (frequent)
_____Heart Disease
_____Hepatitis
_____Juvenile Arthritis
_____Meningitis/Encephalitis
_____Seizures/Epilepsy
_____Sore throat (frequent)
_____Speech difficulties
_____Toothaches/dental problems
_____Urinary tract infections
_____Wetting during day or night

**Illness, Injuries & Hospitalizations (please explain):**

_____

_____

_____

**Medical Home:** Please provide us with your child's current health care provider's name and contact information.

Physician Name:_____

Address:_____

Phone: _____

**Please continue to the back**

**Current Health:** Tell us about any current health conditions or concerns:

_____

_____

_____

**Student Name:**_____

**Allergies:** If your child has any food or environmental allergies, please obtain the Allergy Action Plan form from the school clinic for your child's health record.

| Allergy | Reaction | Treatment |
|---|---|---|
| | | |
| | | |
| | | |
| | | |

**Medications:** Describe medicine your child takes regularly. If your child must take medication at school, please obtain the Medication Administration Authorization form from the school clinic to be completed by you and your child's doctor.

| Medication | Reason | How often? | What time? |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |

Explain any special assistance your child may need during the school day:

_____

Please add any comments or concerns you have about your child's health, development, behavior, family or home life that you would like the school to be aware of:

_____

If you have questions or concerns about your child's health or would like information about a medical home for your child or community services that may be available, please contact your school clinic.

_____ _____

Signature of person completing form Date