Valley Local School District
Ohio School Health History

Building: ☐ Elementary (PS-4) ☐ Middle School (5-8) ☐ High School (9-12) **Teacher/Homeroom:** _____

Grade Level: ☐ PS ☐ K ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10 ☐ 11 ☐ 12

Student Name: _____ **Student Cell**: _____

Street Address: _____ **P.O. Box** _____

City: _____ **Zip**: _____ **Home Telephone**: _____

Gender: ☐ Male ☐ Female **Birthdate:** _____

Person(s) with whom the student <u>resides</u>: ☐ Both Parents ☐ Mother ☐ Father ☐ Guardian

Mother's Name | Home Phone | Cell Phone | Work Phone

Street Address/PO Box **(If different than Student)** | City | State | Zip

Father's Name | Home Phone | Cell Phone | Work Phone

Street Address/PO Box **(If different than Student)** | City | State | Zip

Legal Guardian's Name(If other than Parent) | Home Phone | Cell Phone | Work Phone

Street Address/PO Box **(If different than Student)** | City | State | Zip

Please list this child's brothers and/or sisters in school at Valley:

Name: _____Grade:_____ Name: _____Grade:_____

Name: _____Grade:_____ Name: _____Grade:_____

Name: _____Grade:_____ Name: _____Grade:_____

Allergies

☐ Bee/Insect _____ _____
Reaction | School restrictions or recommended actions

☐ Food _____ _____
Reaction | School restrictions or recommended actions

☐ Medication _____ _____
Reaction | School restrictions or recommended actions

☐ Other _____ _____
Reaction | School restrictions or recommended actions

➡ ➡ ➡ **<u>Reverse side must also be completed</u>** ➡ ➡ ➡

Health Conditions

☐ **YES**, my child receives regular medical/health care for the following conditions: ☐ **NO** medical conditions

☐ Allergies	☐ Diabetes	☐ Neuromuscular disorder
☐ Asthma	☐ Dental problems	☐ Seizure disorder
☐ ADD/ADHD	☐ Depression	☐ Sickle Cell Anemia
☐ Autism	☐ Ear problem/hearing difficulty	☐ Skin conditions
☐ Behavior concerns	☐ Emotional concerns	☐ Speech problems
☐ Birth/congenital malformations	☐ Headaches	☐ Traumatic brain injury
☐ Bone/muscle/joint problems	☐ Heart problems	☐ Vision problems (glasses, contacts)
☐ Blood problems	☐ Hemophilia	☐ Other_____
☐ Bowel/bladder problems	☐ Juvenile arthritis	☐ Other_____
☐ Cancer	☐ Lead poisoning	☐ Other_____
☐ Cystic Fibrosis	☐ Migraines	☐ Other_____

Please explain any conditions above or any reasons for hospitalizations._____

_____

_____

Medications

Please list any prescription and over the counter medication that your child takes on a regular basis.

Medication and dose	Time	Reason
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Additional Information

Do any health and/or medical conditions require school restrictions, modifications, and/or intervention?

☐ Yes ☐ No If YES, please explain_____

_____

_____

Does the student require any special procedures and/or treatments for their health condition(s)?

☐ Yes ☐ No If YES, please 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
_____	_____	_____