

**CUYAHOGA COUNTY BOARD OF HEALTH
DIVISION OF NURSING
School Health Service Program**

School Entrance Health History and Immunization Information

Name		Grade	
Address		Phone	
School	Previous School		Birth date
Name of Physician		Phone	
Name of Dentist		Phone	

HEALTH HISTORY

Allergies - List and describe reactions:

Insect stings	
Food/plants/animals	
Medications	
Recommended treatment	
Asthma YES <input type="checkbox"/> NO <input type="checkbox"/> Treatment required:	
Bone/Joint disorder YES <input type="checkbox"/> NO <input type="checkbox"/> Describe:	
Blood disorders YES <input type="checkbox"/> NO <input type="checkbox"/> Describe:	
Cancer YES <input type="checkbox"/> NO <input type="checkbox"/> Explain:	
Convulsions/seizures YES <input type="checkbox"/> NO <input type="checkbox"/> Frequency: Medication:	
Diabetes YES <input type="checkbox"/> NO <input type="checkbox"/> Age of onset: Treatment:	
Ear Infections YES <input type="checkbox"/> NO <input type="checkbox"/> Frequency: Age of last infection: Tubes YES <input type="checkbox"/> NO <input type="checkbox"/>	
Hearing problems YES <input type="checkbox"/> NO <input type="checkbox"/> Describe: Hearing aids: YES <input type="checkbox"/> NO <input type="checkbox"/>	
Heart Disease YES <input type="checkbox"/> NO <input type="checkbox"/> Describe:	
Chicken pox disease YES <input type="checkbox"/> NO <input type="checkbox"/> Date::	
Kidney Disease YES <input type="checkbox"/> NO <input type="checkbox"/> Describe:	
Nervous system disorder YES <input type="checkbox"/> NO <input type="checkbox"/>	
Skin disorder YES <input type="checkbox"/> NO <input type="checkbox"/> Describe:	
Stomach/intestinal disorders YES <input type="checkbox"/> NO <input type="checkbox"/> Describe:	
Strep infections YES <input type="checkbox"/> NO <input type="checkbox"/> Frequency:	
Vision problems YES <input type="checkbox"/> NO <input type="checkbox"/> Describe:	
Treatment: Glasses: YES <input type="checkbox"/> NO <input type="checkbox"/> <input type="checkbox"/> Near <input type="checkbox"/> Far	
Other physical disabilities: Describe:	
Past Hospitalizations/Surgeries:	
Medications: (If any medication needs to be administered in school, physician must complete school physical examination form).	
Please list: Name _____ Dose _____ Time to be taken _____ AM / PM Reason for medicine	

Please make sure immunization is completely filled out on the other side or attach immunization records.

Parent/guardian signature

Date

**CUYAHOGA COUNTY BOARD OF HEALTH
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School Health Service Program
School Entrance Physical Examination**

Name: _____ Birth date: _____ Grade: _____

Immunization Information

Please complete the entire date including day, month and year.

DTP/DTaP/DT/Td	1.	2.	3.	4.	5.
Polio-OPV/IPV	1.	2.	3.	4.	
Hib	1.	2.	3.	4.	
HEP B	1.	2.	3.	4.	
MMR	1.	2.	Hepatitis A	1.	2.
Varicella	1.	2.	3.	Other:	

Height: _____ Weight: _____ Blood Pressure: _____
 Examination: Date: _____ Normal: _____ Abnormal: _____

Remarks and recommendations concerning abnormal findings: _____

Restrictions: _____ Development: Normal _____ Abnormal _____

Chronic Health Concerns: Asthma Seizure Disorder ADD/ADHD Diabetes
 Other: _____

Was child referred to a specialist for any reason? Explain _____

Special Tests (at discretion of physician):

Urinalysis _____ Hemoglobin _____
 Lead _____ Sickle Cell _____
 Tuberculin test (most recent) Date _____ Type _____ Results: Positive Negative
 Other _____

Hearing: Type of test _____ Results _____ Comments _____

Vision: Acuity Right - 20/ _____ Left - 20/ _____ Strabismus: Yes No Comments _____

Medications:

Name of Medication/Dosage/Frequency _____
 Reason for medication _____

***Please complete a separate form for medication administration if it is necessary
 for the child to receive prescription or OTC medication in school.***

Physician name (Print) _____ Phone _____

Street Address / City / State/ Zip _____

Based on examination consistent with EPSDT/Headstart/AAP guidelines. I certify this child to be in suitable condition for enrollment in school.

Physician Signature: _____ Date: _____