Twin Valley Community Local School District
100 Education Drive – West Alexandria, OH 45381
Phone: 937-893-4688
Fax: 937-839-4898

Student Health History

Child's Full Name: _____ ☐Female ☐Male Date of Birth: _____

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

Mother: _____

Father: _____

Brothers & Sisters: _____

Birth & Developmental History

Any unusual birth or developmental history? ☐Yes ☐No

Did the Mother have any unusual physical or emotional illness during this pregnancy? ☐Yes ☐No

Was this infant born: ☐ Early ☐ Full Term ☐ Late Did 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

☐ 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, Contacts)
☐ Bone/Muscle/Joint Problems	☐ Hemophilia	☐ Other: _____
☐ Blood Problems	☐ Juvenile Arthritis	☐ Other: _____
☐ Bowel/Blatter Problems	☐ Lead Poisoning	☐ Other: _____
☐ Cancer	☐ Migraines	☐ Other: _____
☐ Cystic Fibrosis	☐ Neuromuscular Disorder	☐ Other:

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

Has your child had Chickenpox? ☐Yes ☐No If yes, date: _____

Allergy Information – *Please indicate any allergies your child may have.*

Allergy Type	Reaction	School Restrictions or Recommended Actions
☐ Bee/Insects:		
☐ Food		
☐ Medication		
☐ Other		

Student Health History

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

- It is recommended to parent, with their physician's counsel, that the medication schedule should be adjusted to avoid administering medication during school hours.
- If this is not possible, the Medication Request form (available in school office & website) must be completed by the parent and physician and on file in the office before the student will be allowed to take medication during school hours.
- Medications must be brought to the school office by an adult in the original container.
- Any unused medication unclaimed by the parent will be destroyed by school personnel at the end of the school year.

Medication & Dose	Time	Reason

Is your child receiving any special services for medical or developmental problems? ☐Yes ☐No

If yes: ☐Speech ☐OT ☐PT ☐IEP ☐504 Plan ☐Other: _____

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: _____

Has your child received vision or dental treatment? ☐Yes ☐No

If yes, please explain: _____

Does your child have a medical home? ☐Yes ☐No

If yes, Contact information: _____

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

Note: Your child's health and education are very important to us. The above information will be used to facilitate your child's learning. Informing and educating staff about your child's needs will help promote his /her well being.

I give my permission to share health information with school staff and administration as needed. ☐ Yes ☐ No

Signature of Parent or Legal Guardian: _____ Date: _____

Home Phone#: _____ Work Phone#: _____ Cell #: _____