





**Rittman School District  
New Student Health History**

Student's Full Name \_\_\_\_\_

Sex  
 Male  Female

Date of Birth  
 / /

**Student's Health Conditions**

Please indicate those items your child receives regular medical / health care for:

NO	YES	
<input type="checkbox"/>	<input type="checkbox"/>	Asthma
<input type="checkbox"/>	<input type="checkbox"/>	Bedwetting
<input type="checkbox"/>	<input type="checkbox"/>	Chickenpox ( Date or age _____ )
<input type="checkbox"/>	<input type="checkbox"/>	Diabetes
<input type="checkbox"/>	<input type="checkbox"/>	Diagnosed Attention Deficit Disorder (ADD)
<input type="checkbox"/>	<input type="checkbox"/>	Diagnosed Hyperactivity (ADHD)
<input type="checkbox"/>	<input type="checkbox"/>	Epilepsy
<input type="checkbox"/>	<input type="checkbox"/>	Frequent ear infections
<input type="checkbox"/>	<input type="checkbox"/>	Heart Condition Please be specific _____
<input type="checkbox"/>	<input type="checkbox"/>	Speech / Language concerns _____
<input type="checkbox"/>	<input type="checkbox"/>	Other _____

Please indicate those allergies that effect your child:

NO	YES	
<input type="checkbox"/>	<input type="checkbox"/>	Bee / Insect
<input type="checkbox"/>	<input type="checkbox"/>	Food Please be specific _____
<input type="checkbox"/>	<input type="checkbox"/>	Medication Please be specific _____
<input type="checkbox"/>	<input type="checkbox"/>	Other _____

**ADDITIONAL INFORMATION**

What medications are given daily? \_\_\_\_\_

What medications are given frequently, but not daily? \_\_\_\_\_

Has your child had a comprehensive eye exam?  No  Yes By Whom \_\_\_\_\_

Does your child wear glasses?  No  Yes

Has your child had a comprehensive hearing exam?  No  Yes By Whom \_\_\_\_\_

Has your child experienced a reduction in hearing?  No  Yes

**This information is for school use only and will not be released to unauthorized persons.**

Signature of Legal Parent / Guardian \_\_\_\_\_

Date completed \_\_\_\_\_

**Appendix A: Language Usage Survey**

Parents and Guardians: Please only complete this page of the survey. The back of this form will be completed by the school. A completed language usage survey is required for all students upon enrollment in Ohio schools. This information will tell school staff if they need to check your child's proficiency in English. Answers to these questions ensure your child receives the education services to succeed in school. The information is not used to identify immigration status.

<b>Student Name: (First Name and Last Name)</b> _____		<b>Student Date of Birth: (mm/dd/yyyy)</b> _____	
<b>Communication Preferences</b> Indicate your language preference so we can provide an interpreter or translated documents at no cost when you need them. All parents have the right to information about their child's education in a language they understand.	1. In what language(s) would your family prefer to communicate with the school? _____		
	<b>Language Background</b> Information about your child's language background helps us identify students who qualify for support to develop the language skills necessary for success in school. Testing may be necessary to determine if language supports are needed.		
<b>Prior Education</b> Responses about your child's birth country and previous education give us information about the knowledge and skills your child is bringing to school and may enable the school to receive additional funding to support your child.	2. What language did your child learn first? _____		
	3. What language does your child use the most at home? _____		
<b>Additional Information</b> Please share additional information to help us understand your child's language experiences and educational background.	4. What languages are used in your home? _____		
	5. In what country was your child born? _____		
6. Has your child ever received formal education outside of the United States? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, how many years/months? _____ If yes, what was the language of instruction? _____		7. Has your child attended school in the United States? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, when did your child first attend a school in the United States? _____ / _____ / _____ Month      Day      Year	
Parent/Guardian First Name: _____ Parent/Guardian Last Name: _____ Parent/Guardian Signature: _____ Today's Date: (mm/dd/yyyy) _____			

Thank you for providing the information above. Contact your school or district office if you have questions about this form or about services available at your child's school. Translated information about schools' civil rights obligations to English learner students and limited English proficient parents can be found here: <https://www2.ed.gov/about/offices/list/ocr/eilresources.html>

