

Student Name _____

Date Completed _____

Mother

Father

| Parent's Name | Mother | Father |
|---------------|--------|--------|
| Home Address | | |
| Telephone | | |
| Work Place | | |

SPECIAL HEALTH NEEDS (Circle Yes or No)

Has the pupil ever had any serious illness or operations? No Yes

What? _____ When? _____

Is the pupil going to a hospital, clinic or doctor now? Clinic Name _____ No Yes

What for? _____ Doctor Name _____

Apart from vitamins, is the pupil taking any medicine, tablets or drugs: No Yes

What? _____ When? _____

Does the pupil need to take any medicine, tablets, or drugs at school? No Yes

What? _____ When? _____

Is the pupil allergic to anything, such as foods, plants, insects, medicine? No Yes

What? _____

Has the pupil had any convulsions (fits, seizures) in the past year? No Yes

How many? _____ Treatment _____

Does the pupil need a special diet or have any food problems? No Yes

Give details _____

Does the pupil have any special health needs or problems the school should know? No Yes

What? _____

Has the child had any other illnesses, accidents, broken bones? No Yes

When? _____ What was the problem? _____

Has the child ever been seen by a dentist? No Yes

Name of Dentist _____

Name of Primary Care Physician _____

STUDENT'S HEALTH HISTORY (Entry)

A. Prenatal Health History (Circle Yes or No)

- Did the mother have any illness during the pregnancy?..... No Yes
- Did the mother take any medicines or drugs (other than iron or vitamins) during the pregnancy?..... No Yes
- Did the baby come on time?..... No Yes

B. Developmental History

- What was the baby's birth weight?..... _____
- Did the baby have any trouble while in the hospital?..... No Yes
- At what age did the child sit alone without support?..... _____
- At what age did the child walk alone without support _____
- At what age did the child begin to say two or three words together?..... _____
- *Can the child use the toilet without help? If No, note on page 4..... No Yes
- If the child has stopped wetting the bed, at what age did he or she stop? _____

C. Family Health History

Circle any of the following diseases that this child's parents, grandparents, aunts, uncles, brothers, sisters, have had:

Allergy, asthma, cancer, drug or alcohol addiction, diabetes, heart disease, nervous breakdown, seizures, tuberculosis, lead poisoning, sickle cell, vision, hearing, learning problems, anemia, other inherited or family diseases.

Family Members (note any special relationship such as step-parent, adopted, foster-child, etc.)

| Relationship | Age | Name | State of Health | Occupation Or School | Grade Reached In School |
|--------------|-----|------|-----------------|----------------------|-------------------------|
| Mother | | | | | |
| Father | | | | | |
| Brothers | | | | | |
| | | | | | |
| | | | | | |
| Sisters | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |

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D. Health History

Check any of the following illnesses the child has had:

- | | | |
|--|--|---|
| <input type="checkbox"/> "Red" Measles | <input type="checkbox"/> German or "3 Day Measles" | <input type="checkbox"/> Whooping cough |
| <input type="checkbox"/> Chicken Pox | <input type="checkbox"/> Rheumatic Fever | <input type="checkbox"/> Pneumonia |

(Circle Yes or No)

- | | | |
|--|----|-----|
| Has the child had more than six colds or throat infections, with a fever, in a year? | No | Yes |
| Has the child had any trouble with ears or hearing?..... | No | Yes |
| Has the child had any trouble with eyes or seeing?..... | No | Yes |
| Has the child had any trouble with teeth?..... | No | Yes |
| Has the child ever had a fainting spell?..... | No | Yes |
| Does the child complain of headaches?..... | No | Yes |
| Has a doctor ever said the child had a heart murmur?..... | No | Yes |
| Do any foods disagree with the child? | No | Yes |
| Does the child often have diarrhea? | No | Yes |
| Has constipation ever been much of a problem for this child?..... | No | Yes |
| Has the child ever had worms or parasites?..... | No | Yes |
| Have you ever seen blood in the child's stools (bowel movements)?..... | No | Yes |
| Has the child ever had yellow jaundice or trouble with the liver? | No | Yes |
| Does the child complain of bellyaches? | No | Yes |
| Does the child have any problems with passing water (urination)? | No | Yes |
| Does the child have any skin problems? | No | Yes |
| Has the child ever had eczema or allergy? | No | Yes |
| Has the child ever had asthma or wheezing?..... | No | Yes |
| Has the child ever had an allergy or reaction to any medicines or injections?..... | No | Yes |
| If yes, what was the medicines or injections? _____ | | |
| Does the child seem to have trouble breathing through the nose? | No | Yes |
| Does the child snore at night? | No | Yes |
| Has the child ever complained of pain in the arms or legs? | No | Yes |
| Has the child ever had swelling or any joints or limping? | No | Yes |
| Has there ever been any trouble with the child's blood?..... | No | Yes |
| Does the child have any trouble sleeping? | No | Yes |

E. Put a circle around any of the following things which worry you about the child:

- | | | |
|------------------------------|--|---------------------------------|
| Bed wetting | Wetting during the day | Thumb sucking |
| Stammering or stuttering | High strung or easily upset | Too restless |
| Shy | Sad and sulky | Feeling easily hurt |
| Wanting too much attention | Day dreams | Nightmares |
| Temper tantrums | Contrary or stubborn | Disobedient |
| Lying | Selfish in sharing | Jealous of brothers and sisters |
| Fighting with other children | Purposely destroys things | Feeding |
| Bowels | Wanting too much comfort or support from parents | |

Any other problems not mentioned? What? _____

Signature

Date