CONRAD WEISER AREA SCHOOL DISTRICT

STUDENT HEALTH HISTORY

Student's Name _____ Date of Birth _____

A. Family History:

FAMILY HOUSEHOLD MEMBERS				
Relationship	Age	Name	Occupation/School	Grade Reached
Mother				
Father				
Siblings				
Other household members				

1. What language is spoken in the home? _____ Are there any other languages used sometimes in the home? No____ Yes____ If yes, Indicate Language _____

2. Check any of the following that your child's parents, grandparents, siblings, aunts or uncles have had and **INDICATE WHICH RELATIVE** has had the condition:

allergy _____ asthma _____ diabetes _____
cancer_____ heart disease_____ seizures_____
tuberculosis_____ migraines_____ lead poisoning_____
substance abuse_____ depression_____ sickle cell disease/trait_____

B. Pregnancy and Birth:

Pregnancy: ☐ Full-term pregnancy
☐ Complications during pregnancy _____
☐ Natural birth ☐ Complications after birth_____
☐ Cesarean Birth ☐ Number of weeks born prematurely: _____weeks

What was your child's birth weight? _____

Problems in the first 6 months of life:
_____breathing difficulties
_____ jaundice
_____feeding difficulties
_____ infections
_____seizures

Early growth & Development:
_____ age child began to sit alone
_____ age child began to walk
_____ age child began to talk in phrases
_____ age child fully bladder trained
_____ age child fully bowel trained

C. Medical history:

1. Has your child ever been in the hospital or had an operation?
When? _____ Please explain: _____
_____

2. Has your child had any serious illnesses, accidents or broken bones?
   When? _____ Please explain: _____
   _____

3. Has your child ever seen a medical specialist?
   When? _____ Please explain: _____
   _____

4. List any medications, vitamins or herbs your child is currently taking and reasons for taking them:
   _____
   _____

5. Is your child allergic to anything such as food, medication, insects or plants? ☐ No ☐ Yes
   If yes, to what? _____ Reaction to allergen: _____
   _____ _____
   _____ _____

6. Does your child require medication(s) such as an Epinephrine Auto-Injector for **SEVERE** allergies at school? If so, please list name of medication and dosage:_____

7. Please check any of the following that your child has had:
   - ☐ pneumonia
   - ☐ asthma
   - ☐ seasonal allergies
   - ☐ eczema or other skin conditions
   - ☐ heart murmur
   - ☐ attention deficit disorder (ADHD)
   - ☐ swelling of any joint or limping
   - ☐ painful or frequent urination
   - ☐ frequent headaches or migraines
   - ☐ frequent stomachaches
   - ☐ gastro-esophageal reflux (GERD)
   - ☐ frequent diarrhea or constipation
   - ☐ seizures
   - ☐ lead poisoning (date of onset: _____)
   - ☐ chickenpox (date of illness: _____)
   - ☐ trouble with teeth (date of last dental visit: _____)

   Check any of the following behaviors that worry you:
   - ☐ bedwetting
   - ☐ wetting/soiling during the day
   - ☐ frequent temper tantrums
   - ☐ sensitivity to loud noise or bright lights
   - ☐ purposefully destroys things
   - ☐ easily distracted or has trouble focusing on sustained activities
   - ☐ nightmares
   - ☐ eating or dietary habits
   - ☐ difficulty with changing routines
   - ☐ feelings easily hurt
   - ☐ difficulty getting along with peers

8. Does your child have any vision, hearing, or speech problems?
   If so, please list name of problem and corrections made: _____
   _____
   _____

9. Does your child have any special health needs that the school nurse should be aware of? Please provide information that will be helpful for the nurse to assist your child during the school day:
   _____
   _____
   _____
   _____

Parent/Guardian signature: _____Date: _____