Student Health History

Child's Full Name: _____ Birthdate: _____
Child's Sex: [ ] male [ ] female Mother: _____ Father: _____
Last Physical Examination: _____

FAMILY HISTORY

Please list child's brothers and sisters including natural, step or foster children:

	Name	Birth year	Sex	Health issues
1.	_____	_____	____	_____
2.	_____	_____	____	_____
3.	_____	_____	____	_____
4.	_____	_____	____	_____
5.	_____	_____	____	_____
6.	_____	_____	____	_____
7.	_____	_____	____	_____
8.	_____	_____	____	_____

PERINATAL HISTORY

Is child adopted? [] yes [] no If yes, at what age: _____
How old was mother when child was born? _____ Was the child a twin? [ ] yes [ ] no
Was child born: [] full term [] early [] late Child's birth weight? _____
Did the child have any sickness or problems at birth? [] yes [] no If yes, explain briefly: _____
_____

DEVELOPMENTAL HISTORY

How does this child's development compare to other children such as brothers/sisters or friends:
[ ] about the same [ ] delayed [ ] advanced
Do you have any developmental concerns? _____
_____

HEALTH CONDITIONS

(Please check any that this child has had)

[ ] **YES**, my child receives regular medical care for the following conditions:

___ Allergies
___ Asthma
___ ADD/ADHD
___ Autism
___ Behavior concerns
___ Birth/Congenital Malformations
___ Bone/muscle/joint problems
___ Bleeding problems
___ Bowel/Bladder problems
___ Cancer, Type: _____
___ Cystic fibrosis
___ Diabetes
___ Depression
___ Ear/Hearing difficulty
___ Emotional concerns
___ Headaches
___ Heart problems
___ Hemophilia
___ Juvenile arthritis
___ Lead poisoning
___ Migraines
___ Neuromuscular disorder

[ ] **No** Medical conditions

___ Seizure disorder
___ Sickle cell anemia
___ Skin conditions
___ Speech problems
___ Traumatic Brain Injury
___ Vision problems
__ glasses __contacts
Other: _____
Other: _____
Other: _____

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

Continued

Student Health History

ALLERGIES

(Please indicate allergies your child may have)

Allergy Type:

[] Medications _____ Reaction _____ Treatment _____
[] Bee/Insect: _____ Reaction _____ Treatment _____
[] Food: _____ Reaction _____ Treatment _____
[] Other: _____Reaction _____ Treatment_____

ADDITIONAL INFORMATION

Does this child have yearly regular dental check-ups? [] yes [] no Last Dental Exam: _____
Any Dental issues? _____

Please list any prescription or non-prescription medications your child takes:

Medication _____Dose _____ Time _____ Reason _____
Medication _____Dose _____ Time _____ Reason _____
Medication _____Dose _____ Time _____ Reason _____
Medication _____Dose _____ Time _____ Reason _____

Any health/medical conditions require school restrictions, modification or intervention? [ ] yes [ ] no
If yes, please explain: _____

Does the student require any special procedures/treatments for any health conditions? [ ] yes [ ] no
If yes, explain: _____

This child is usually: [ ] very active [ ] normally active [ ] rather inactive

Do you have any concern about how your child gets along with other children? [ ] yes [ ] no
If yes, explain: _____
_____
_____
_____

Do you have other comments or concerns about this child's health, development, behavior, family or home life that you would like the school to be aware of? [ ] yes [ ] no
If yes, explain briefly: _____
_____
_____
_____
_____

Form Completed by: _____ Relationship to child: _____
Date Completed: ____/____/____

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