HEALTH HISTORY

NAME OF CHILD _____ DATE OF BIRTH _____
LAST FIRST MIDDLE

DEVELOPMENTAL HISTORY

Pregnancy and Birth:

1. Did mother have any illness during pregnancy?_____
2. Did mother take medication? Name of medication_____
3. Was baby premature?_____
4. Was delivery long or complicated?_____
5. Was the infant placed in an incubator?_____
6. What was birth weight?_____
7. Were there any health problems at birth? If so, explain_____

_____

Early childhood development:

1. Did baby have any special problems in the first six months?_____
2. Was your child late in starting to talk? Yes _____ No_____
3. Does your child wet the bed?_____
4. Does your child suck his/her thumb?_____

Please circle below if your child has or has had any of the following:

ANEMIA	HEART PROBLEM	SORE THROATS-FREQUENT
ASTHMA OR WHEEZING	HIVES	DIABETES
ENCEPHALITIS/MENINGITIS	KIDNEY INFECTIONS/DISEASE	RHEUMATIC FEVER
EAR INFECTIONS-FREQUENT	SEIZURES, CONVULSIONS	WORMS (INTESTINAL)
ECZEMA OR SKIN ALLERGY	HEMOPHILIA	CHICKEN POX
VISION PROBLEMS	HEART MURMUR	HEPATITIS
HAY FEVER	REACTION TO BEE STINGS	NOSE BLEEDS

GIVE DETAILS OF:

ALLERGY TO BEE STING _____
ALLERGY TO MEDICINE (WHICH ONE?)_____
OPERATIONS/HOSPITAL/SERIOUS ILLNESS, IF YES, PLEASE EXPLAIN:_____
IS YOUR CHILD PRESENTLY GOING TO A DOCTOR, HOSPITAL OR CLINIC? IF YES, EXPLAIN
_____
NAME OF CHILD'S PRIMARY CARE PHYSICIAN_____
DOES YOUR CHILD TAKE MEDICATION(S) NO _____YES_____IF YES, WHAT?_____
_____

* *MEDICATION WILL BE ADMINISTERED AT SCHOOL ONLY ACCORDING TO CURRENT SCHOOL POLICIES.

FAMILY MEDICAL HISTORY

HAS ANYONE IN YOUR FAMILY HAD THE FOLLOWING: PLEASE CIRCLE.

			IF YES, GIVE RELATIONSHIP TO CHILD
YES	NO	TUBERCULOSIS	_____
YES	NO	HEART DISEASE	_____
YES	NO	HIGH BLOOD PRESSURE	_____
YES	NO	ALLERGIES	_____
YES	NO	DIABETES	_____
YES	NO	OTHER	_____

_____ _____
SIGNATURE OF PARENT/GUARDIAN DATE