

H- 7 2010- 2011
LOWER SCHOOL HEALTH HISTORY
Required: EC through Grade 5



Deadline: August 1, 2010

Student Name: _____ **Grade:** _____ **Date of Birth** _____

Social Service History

Mark the box if you have contact with any of the following agencies:

- Child Protective Services (if yes, Case worker's name): _____
 Legal/Court System Family Counseling Services Mental Health Provider Other: _____

Mark the box if you or your child receive any of the following medical assistance:

- SSI, Disability Healthy Start Insurance (Blue Cross/Blue Shield, HMO)
 LEAP Medicaid/CHIP Other: _____

Family History

Please list the first and last name of all the child's family members, including parents and siblings

Name	DOB	Gender	Health Concerns	Is child in school?	If so, where?
1. _____					
2. _____					
3. _____					
4. _____					
5. _____					

Perinatal History

Did the mother have any unusual physical or emotional illness during this pregnancy?

- Yes No If yes, please explain: _____

How old was the mother when the child was born? _____ Was the infant: Full term Early Late

What was the child's birth weight? ___lbs ___oz Did the child have any sickness or problems at birth?

- Yes No If yes, please explain: _____

Developmental History

Please give the approximate age at which the child:

Walked alone: _____ Spoke in sentences: _____ Toilet trained: _____ Dressed self: _____

How does the child's development compare to other children, such as his or her siblings or playmates?

- About the same Delayed Advanced Comments: _____

Behavioral History

The child is usually: Very active Normally active Rather inactive

Has your child ever been violent or acted out in the following manner towards adults or children?

- Hitting Kicking Biting Fighting Scratching Other: _____

Do you have any concerns about how your child gets along with other children? Yes No

If you answered yes above, please explain: _____

Please add any comments or concerns you have about your child's health, development, behavior, family, or home life that you would like the school to be aware of: _____

Has the student been enrolled in special education courses or assistance? Yes No

PLEASE COMPLETE REVERSE SIDE →

H- 7 continued

LOWER SCHOOL HEALTH HISTORY

Health Conditions

Please check any medical conditions that the child currently has or had in the past:

- | | | |
|--|---|--|
| <input type="checkbox"/> Abnormal spinal curvature (Scoliosis) | <input type="checkbox"/> Allergies/Hayfever | <input type="checkbox"/> Anemia |
| <input type="checkbox"/> Anaphylactic reaction | <input type="checkbox"/> Asthma or wheezing | <input type="checkbox"/> Attention Deficit Disorder |
| <input type="checkbox"/> Behavior problems | <input type="checkbox"/> Birth malformation | <input type="checkbox"/> Cancer: type _____ |
| <input type="checkbox"/> Chicken pox: when _____ | <input type="checkbox"/> Chronic diarrhea/constipation | |
| <input type="checkbox"/> Chronic ear infections | <input type="checkbox"/> Concern about relations with siblings or friends | |
| <input type="checkbox"/> Cystic Fibrosis | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Eczema/Chronic skin cond. |
| <input type="checkbox"/> Emotional problems | <input type="checkbox"/> Eye problems, poor vision | <input type="checkbox"/> Frequent headaches |
| <input type="checkbox"/> Frequent sore throat | <input type="checkbox"/> Heart disease: type _____ | <input type="checkbox"/> Hemophilia |
| <input type="checkbox"/> Hepatitis | <input type="checkbox"/> HIV positive | <input type="checkbox"/> Hyperactivity |
| <input type="checkbox"/> Juvenile Arthritis | <input type="checkbox"/> Kidney disease- type _____ | <input type="checkbox"/> Measles (10 day) |
| <input type="checkbox"/> Meningitis or Encephalitis | <input type="checkbox"/> Mumps | <input type="checkbox"/> Mutism |
| <input type="checkbox"/> Near-drowning, near-suffocation | <input type="checkbox"/> Nervous twitches or tics | <input type="checkbox"/> Poisoning |
| <input type="checkbox"/> Rheumatic fever | <input type="checkbox"/> Seizure disorder/ epilepsy | <input type="checkbox"/> Sickle Cell Disease |
| <input type="checkbox"/> Speech difficulties | <input type="checkbox"/> Stool soiling | <input type="checkbox"/> Toothache/ dental problems |
| <input type="checkbox"/> Tourette's Syndrome | <input type="checkbox"/> Urinary tract infection | <input type="checkbox"/> Wetting during day or night |

Allergies

Please list and describe allergies or reactions

Medications/drugs: _____

Foods/plants/animals/other: _____

Recommended treatment if allergy is severe: _____

Injuries, Illnesses and Hospitalizations

Please list any severe injuries, illnesses and hospitalizations including inpatient and outpatient surgeries.

<u>Injury/Illness/Hospitalization</u>	<u>Age</u>	<u>If hospitalized, please explain:</u>
_____	_____	_____
_____	_____	_____
_____	_____	_____

Medication Information

Please describe any medications that your child takes daily and frequently.

<u>Name of Medication</u>	<u>Purpose of medication</u>	<u>Frequency and time of day</u>
_____	_____	_____
_____	_____	_____
_____	_____	_____