STUDENT HEALTH AND DEVELOPMENTAL HISTORY

Understanding your child's health and family background will help us to provide an optimum school program. This information will be a part of your child's confidential school record.

Student's name _____ Age_____ DOB _____
School_____ Grade_____
Home Address _____ Home Phone _____
Parents/Guardian name _____Last School Attended_____
Preschool Experience _____

DATA OF FAMILY MEMBERS LIVING IN HOUSEHOLD:

NAME	RELATIONSHIP	DOB	LEARNING PROBLEMS?	HEALTH PROBLEMS?

HEALTH DURING PREGNANCY:
From what month did you receive medical care? _____
While pregnant, did you:

Take medications? ☐ Yes ☐ No If yes, which ones? _____
Smoke? ☐ Yes ☐ No If yes, how much? _____
Drink alcohol? ☐ Yes ☐ No
Take drugs? ☐ Yes ☐ No
Have high blood pressure? ☐ Yes ☐ No
Have Toxemia? ☐ Yes ☐ No
Have Anemia? ☐ Yes ☐ No
Require bed rest? ☐ Yes ☐ No

Please note any complications during pregnancy; any illness or injury to mother, high fevers, unusual stress, etc.:

_____

_____

_____

BIRTH HISTORY:
Was your child's birth:

Two weeks past due? ☐ Yes ☐ No How late? _____ Length of your labor? _____
Premature birth? ☐ Yes ☐ No How early? _____
Cesarean delivery? ☐ Yes ☐ No Reason? _____

PRENATAL AND NEONATAL HISTORY:

Birth weight of baby ___ lbs ___ozs
Breathing difficulty? ☐ Yes ☐ No
Was oxygen given? ☐ Yes ☐ No How long? _____
Was the baby jaundice? ☐ Yes ☐ No
Baby kept in hospital? ☐ Yes ☐ No How long? _____
Other birth complications, injury, or diagnosed defects (e.g., seizures, heart problems, etc.) Please explain:

_____

_____

DEVELOPMENTAL MILESTONES:

Sat alone:	☐ 6-8 months	☐ 8-10 months		If later, when? _____
Crawled:	☐ 6-9 months	☐ 9-12 months		If later, when? _____
Walked alone:	☐ 8-12 months	☐ 12-14 months	☐ 14-18 months	If later, when? _____
Said single words:	☐ 8-12 months	☐ 12-18 months	☐ 18-24 months	If later, when? _____
Said phrases:	☐ 1 year	☐ 2 years	☐ 3 years	If later, when? _____

Speech problems? ☐ Yes ☐ No Therapy? ☐ Yes ☐ No

Age toilet trained? _____

Do you remember delays in development, or a regression? ☐ Yes ☐ No If yes, please explain:

_____

_____

MEDICAL/HEALTH HISTORY: Has your child had a problem in the following areas?

	Yes	No		Yes	No
Physical/motor	☐	☐	Fainting spells/dizziness	☐	☐
Diabetes	☐	☐	Asthma/breathing	☐	☐
Stomach/bowel	☐	☐	Headaches	☐	☐
Heart	☐	☐	Eye/vision	☐	☐
Anemia/blood disorders	☐	☐	Ear/hearing	☐	☐
Tumors	☐	☐	Frequent colds	☐	☐
Leukemia/Cancer	☐	☐	Nosebleeds	☐	☐
Hepatitis/CMV	☐	☐	Skin conditions	☐	☐
Encephalitis/Meningitis	☐	☐	Eating/appetite	☐	☐
Emotional disturbance	☐	☐	Family history of learning disabilities	☐	☐
Psychiatric Care	☐	☐	Serious illness/high fever	☐	☐
Accidents	☐	☐	Genetic disorder	☐	☐
Surgery	☐	☐	Hospitalization	☐	☐

Comments: _____

Allergies: _____

How does this allergy show? _____

Emergency medication required for this allergy (if so, what?) _____

What medication does your child take on a regular basis? _____

SOCIAL, EMOTIONAL, AND BEHAVIORAL DEVELOPMENT: Check all that apply.

☐ Hyperactive	☐ Inattentive	☐ Anxious	☐ Forgetful	☐ Optimistic	☐ Cheerful	☐ Out-going
☐ Positive	☐ Angry	☐ Aggressive	☐ Depressed	☐ Withdrawn	☐ Shy	☐ Passive
☐ Fearful	☐ Moody	☐ Responsible	☐ Cooperative	☐ Disruptive	☐ Respectful	
☐ Poorly motivated		☐ Dependent on others				

Comments: _____

Have there been any changes in family life recently? _____

CURRENT MEDICAL CARE:

Date of child's last physical _____ Provided by Dr. _____

Has your child received care from a medical specialist such as an ENT or Neurologist? ☐ Yes ☐ No

Date of last exam? _____ Name of doctor? _____ Phone _____

Has your child had a vision exam? ☐ Yes ☐ No Date of last exam _____

Results of vision exam: ☐ Passed ☐ Needs glasses for far vision ☐ Needs glasses for reading

Has your child had a Hearing Evaluation by a specialist? ☐ Yes ☐ No Date _____ Dr. _____

Results of hearing exam: ☐ Passed ☐ Failed, monitoring ☐ Needs assistive technology

_____ _____

Parent/Guardian Signature Date

_____ _____

District Nurse Signature Review Date