

Child Health History, continued:

I. Health Conditions – Please check any that this child has had:

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|---|--|---|---|
| <input type="checkbox"/> Abnormal (spinal curvature, scoliosis, etc.) | <input type="checkbox"/> Concern about relation with siblings or friends | <input type="checkbox"/> Frequent sore throat infections | <input type="checkbox"/> Pregnancy |
| <input type="checkbox"/> Allergies or Hay Fever | <input type="checkbox"/> Cystic fibrosis | <input type="checkbox"/> Heart disease, type_____ | <input type="checkbox"/> Rheumatic fever |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Seizures or epilepsy |
| <input type="checkbox"/> Asthma or wheezing | <input type="checkbox"/> Eczema | <input type="checkbox"/> Kidney disease, type_____ | <input type="checkbox"/> Sickle cell disease |
| <input type="checkbox"/> Bedwetting at night | <input type="checkbox"/> Emotional | <input type="checkbox"/> Measles (“old fashioned” or “ten day”) | <input type="checkbox"/> Stool soiling |
| <input type="checkbox"/> Behavior problem | <input type="checkbox"/> Ear problems, poor hearing | <input type="checkbox"/> Meningitis or encephalitis | <input type="checkbox"/> Substance abuse (alcohol, drugs) |
| <input type="checkbox"/> Birth or congenital malformation | <input type="checkbox"/> Eye problems, poor vision | <input type="checkbox"/> Mumps | <input type="checkbox"/> Suicide attempts |
| <input type="checkbox"/> Cancer, type_____ | <input type="checkbox"/> Frequent headaches | <input type="checkbox"/> Near-drowning or near-suffocation | <input type="checkbox"/> Toothaches or dental infections |
| <input type="checkbox"/> Chicken pox Date:_____ | <input type="checkbox"/> Frequent skin infections | <input type="checkbox"/> Nervous twitches or tics | <input type="checkbox"/> Urinary tract infection |
| <input type="checkbox"/> Chronic diarrhea or constipation | | <input type="checkbox"/> Poisoning | <input type="checkbox"/> Wetting during day |

II. Allergies – Please list and describe allergies or reactions to:

Medicines/drugs
Foods/plants/animals/other
Recommended treatment if allergy is severe

III. Injuries and Illnesses – Please list any severe injuries or illnesses:

Injuries/Illnesses	Age of Child	If Hospitalized \checkmark

Does child always wear seatbelts in cars? Yes No

IV. Additional Information

What medications are given daily?
What medications are given frequently, but not daily?

This child is usually: Very Active Normally Active Rather Inactive

Do you have any concern about how your child gets along with other children?
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? If yes, explain briefly.

Completed by:	Date:
Relationship to child:	