SOUTHEAST DELCO SCHOOL DISTRICT

HEALTH H ISTORY

School: _____ Date: _____

Name of Child: Sex: ____ DOB: _____

Address: _____ _____ Town: _____

Name of Child's Physician: _____ Telephone #: _____

Has your child had any of the following? **(Give details and note complications, if any)**

A doctor's note is required for all medications as well as to confirm allergies and conditions below.

1 Allergy: Food allergy_____ Medication Allergy_____

2 Asthma: inhaler/ nebulizer needed in school …Yes …….No

3 Diabetes

4 Epilepsy/ Seizure Disorder

5 Operations

6 Sickle Cell Disease

7 Emotional Problems

8. Chicken Pox

9. Headaches

10. Heart Murmur

11. Fainting Spells

12. Skin Problems

13. Ear infections

14. Bowell / Bladder Problems

15. Toilet Trained...Yes…No

Comments/Details: _____

Serious Accidents/Illnesses: _____

Is your child presently under medical treatment? Yes ___ No ___

Is your child presently taking daily medication? Yes ___ No ___

Ifyes, to either of the above please explain:

PLEASE TURN OVER

Pre-Natal Health History **Put a circle around the answer**

Did the mother have any illness during the pregnancy? .....No Yes

If yes, please explain _____

Did the mother take any medicines , drugs or alcohol (other than iron or vitamins) during her

pregnancy? ..... No Yes

Was the mother/family under any unusual strain/stress during the pregnancy? .....No Yes

Did the baby come on time? ..... No Yes

Was it a difficult birth? ..... No Yes

Developmental History

What was the baby's birth weight? _____

Would you describe the baby as average, quiet or active? _____

Did the baby have any trouble while in the hospital? .....No Yes

If yes, please explain _____

Was weight gained at a normal rate? ..... No Yes

Is the child clumsy, awkward? ..... No Yes

Is he/she able to use a pencil or scissors? ..... No Yes

Was speech delayed? ..... No Yes

Was the baby jaundiced? ..... No Yes

Family Health History

Circle any of the following diseases that this child's parents, grandparents, aunts, uncles, brothers, sisters, have had: Allergy, asthma, cancer, drug or alcohol addiction, diabetes, heart disease, nervous breakdown, seizures, tuberculosis, lead poisoning, sickle cell, vision, hearing, learning problems, anemia, other inherited or family diseases.

_____

Parent/Guardian Signature