

SCHOOL ENTRY HEALTH HISTORY

Child's Full Name: _____ Birthdate: _____

Birth Weight: _____ LB _____ OZ Birthplace: _____

BIRTH AND EARLY DEVELOPMENT:

1. Any special problems during first 6 months? (Circle) **YES / NO**, Explain _____

2. Approximate age when
 - a. Walked without support _____
 - b. Talked, using 2-3 words together _____
 - c. Toilet training completed _____
3. Communicable diseases: If the child had any of these Diseases, please state the year and list any complications.

_____ Mumps	_____ Scarlet Fever	_____ MRSA
_____ Rubella (German measles)	_____ Rheumatic Fever	_____ Other (Specify)
_____ Rubeola (Regular measles)	_____ Hepatitis	
_____ Whooping cough	_____ Chickenpox	

Complications: _____

FAMILY

1. Household Unit: Please list members and any special relationships, such as step-parent, adopted/foster etc.

RELATIONSHIP	BIRTHDATE	BIRTHPLACE	FULL NAME (Include maiden name)	Education level/Occupation	Lives with Student (yes/no)
Mother					
Father					
Other (specify)					
Other (specify)					
Brother(s)					
Sister(s)					

2. Health History: This pertains to the child's parents, siblings, grandparents, aunts, or uncles. List any medical problems (ex. Diabetes, seizures, asthma, alcohol or drug addiction etc.) and/or family problems (ex: death in the family, divorce, problems with housing, food, or employment, etc.) that might affect the child's health or progress in school _____

GENERAL HEALTH BACKGROUND AND SPECIAL HEALTH NEEDS

- Where is the child usually taken for health care (if sick or injured)? Name of doctor &/or hospital:

- Has the child ever had surgery, been admitted to the hospital, suffered a serious illness, accident, broken bone, or required stitches:

DATE	WHAT FOR?	NAME OF HOSPITAL	TREATMENT

- Is the child attending a clinic or receiving other health or developmental services at the present time?
YES_____NO_____ If yes, specify where and for what problems: _____
 - Does the child take any medications on a daily basis? YES_____NO_____ If yes, specify: _____
_____ Will he/she require medicine during school hours (if so, please see SCSD Medication Policy)? Specify: _____
 - Any restrictions from participating in school Phys. Ed. or recess? YES _____ NO _____ If yes, explain: _____
 - Are there any other health needs or problems the school should be aware of: (ex: hearing loss, vision impairment, frequent earaches, nosebleeds, colds, headaches, stomachaches, fainting spells, bedwetting, etc.) YES _____ NO_____ If yes, explain: _____

- Has the child ever had a significant allergic reaction to anything, such as food, medicine, insects, etc.?
YES_____ NO_____ If yes, explain: _____

Type of treatment: _____

- Has the child ever had seizures (convulsions, "spells") YES_____ NO_____ If yes, describe: _____

Type of treatment: _____ Physician Providing Care: _____

- Nutrition: How would you describe your child's appetite and nutrition status? (circle) **GOOD/FAIR/POOR**
 - Does your child need a special diet or have any food problem? YES_____ NO_____ Explain: _____

b. Is your child taking fluoride tablets at present? YES_____ NO_____

c. Has the child ever been examined by a dentist? YES_____ NO_____ Date: _____
Name of Dentist/Office: _____

- Has the child been examined by an Eye Specialist? YES_____ NO_____ Date: _____
Name of Specialist: _____

- Does the family have some way to pay for medical expenses? YES_____ NO_____

(This information aids school health personnel in obtaining medical and dental care through school referrals to clinics and in co-operating with Dept. of Public Assistance/Child Welfare/Public Health Dept.)

Please Circle: Private Insurance

**Insurance through parent's employer
Dept. of Public Assistance**

Union

**Medicare
Medical Assistance.**

Thank you very much for completing this Health History for your son/daughter's School Health Record. Please keep the Health Office informed of any major illness/injury that may occur. (570- 853-4921 ext 1345)

SIGNATURE OF PARENT/GUARDIAN

RELATIONSHIP TO STUDENT

DATE