SCHOOL ENTRY MEDICAL HISTORY

STUDENT FULL NAME: _____ NICKNAME: _____

BIRTHDATE: _____ BIRTHPLACE: _____

***** BIRTH & EARLY DEVELOPMENT *****

Did your child have any special problems at birth or during infancy? Circle: **YES / NO**

If yes, please specify the problem(s): _____

_____

_____

Approximate age your child walked independently _____

Approximate age your child talked putting 2-3 words together _____

Approximate age your child completed toilet training _____

(Please consider sending an extra set of clothing to school for your child in case of an accident)

***** STUDENT BACKGROUND *****

Does your child have any medical history, current medical conditions, or ever been hospitalized? Circle: **YES / NO**

If yes, please specify the problem(s) & dates: _____

_____

_____

_____

Does your child take any medications, herbals, or supplements? Circle: **YES / NO**

If yes, please specify **names** and **doses**: _____

_____

_____

Will your child need to take medications or receive medical treatments in school? Circle: **YES / NO**

(If yes, please see the medication administration policy further in this packet)

Any other health concerns the school should be aware of (ex: hearing or vision problems, activity restrictions, speech difficulties, frequent illness, nosebleeds, headaches, broken bones, stomachaches, fainting spells, developmental delays, emotional or behavioral problems, etc)? _____

_____

_____

Does your child have any food or medication allergies? Circle: **YES / NO**

If yes, please specify the product & the problem(s): _____

_____

Does your child have any special dietary needs or issues? Circle: **YES / NO**

Please specify: _____

_____

Does the family have insurance or some way to pay for medical expenses? Circle: **YES / NO**

Please list the name and phone number for your child's health care providers:

Primary Care Provider: _____
Dentist: _____
Eye Doctor/Specialist: _____
Other Specialist: _____

***** FAMILY *****

Household unit (please include any special relationships, such as step, adoptive, foster, or grand parents or children)

RELATIONSHIP	BIRTHDATE	FULL NAME (Include maiden name)	LEVEL OF EDUCATION	OCCUPATION
Mother				
Father				
Sibling				

Family History: Please provide a brief list of any family medical or other problems (ex: diabetes, seizures, asthma, drug/alcohol dependence, death of a family member, mental health issue, unemployment, divorce, custody issues, etc)

Parents:
_____
Siblings:
_____
Grandparents:
_____
Other:
_____
_____

Thank you for all the information for your child's health record, please let us know of any changes to your child's health status throughout the year and contact us with any questions or concerns you may have.

_____ _____
Parent/Guardian Signature Date