Ambassadors Preparatory Academy

___Grade
Home Room Teacher
_____

School Health Services

HEALTH HISTORY FOR INCOMING STUDENTS

Please complete (PRINT) and return to school nurse as soon as possible.

Date:	Student's First Name:	Last Name:	Race:	Grade:
Parent/Guardian Name:		Relation to Child:		
Home Address:		City:	State:	Zip:

DEVELOPMENTAL HISTORY

Did child's mother experience any difficulties during pregnancy? Yes No

Was the pregnancy full term? (9months) Yes No

If no, please explain:_____

Was the delivery normal? Yes No

If no,please explain:_____

How much did the chid weigh at birth? _____lbs. _____oz.

At what age did the child first:

Crawl_____ Walk_____ Toilet trained_____

HEALTH HISTORY

Has the child ever been hospitalized for any reason? Yes No

If yes, at what age?_____ For how long?_____ For what reason:_____

PLEASE MARK ANY OF THE FOLLOWING THAT YOUR CHILD CURRENTLY HAS OR PREVIOUSLY EXPERIENCED

( ) operations
( ) heart disease
( ) kidney disease
( ) chicken pox
( ) frequent behavior problems
( ) frequent headaches
( ) fainting spells
( ) serious accidents
( ) allergies
( ) bladder problems
( ) dental problems
( ) reaction to immunizations
( ) asthma
( ) seizures

Is the child presently on any medication? Yes No

If yes, please explain:_____

Has the child had any vision problems? Yes No

If yes, please explain:_____

Has the child had any hearing problems? Yes No

If yes, please explain:_____

Does the chid have physical defects? Yes No

If yes, please explain:_____

Are there any physical tasks with which the child may need assistance? Yes No

If yes, please explain:_____

Are there any symptoms that the teacher should be watchful for? Yes No

If yes, please explain:_____

FAMILY HISTORY

Father's Name:_____Age:_____Religion:_____

Occupation:_____ Grade Completed:_____

Mother's Name:_____Age:_____Religion_____

Occupation:_____ Grade Completed:_____

Marital Status of parents: ( ) Married ( ) Separated ( ) Divorced ( ) Single

LIST OF BROTHERS AND SISTERS

Name	**Age**	**Sex**	**Grade**

Does anyone help take care of the child on a regular basis? Yes No

If yes, who?_____Phone Number _____

PERSONAL HISTORY

Please indicate which, if any of the following are problems for the child:

( ) fussiness	( ) thumb sucking	( ) overactive
( ) bad temper	( ) nail biting	( ) very shy
( ) won't mind	( ) speech problems	( ) wets bed)
( ) jealousy	( ) put things in mouth	( ) poor appetite
( ) nightmares	( ) doesn't pay attention	( ) slow to learn

Has the child ever attended preschool? Yes No

If yes, where? _____

Is there anything you can suggest that may assist us in working with the child this year?

_____

_____

_____

_____

Ambassadors Preparatory Academy

School Health Services

___Grade
Home Room Teacher
_____

Previous School Attended: _____

Please complete in print and return to school nurse as soon as possible.

Student's First Name:	Middle Name:	Last Name:	Date of Birth:
Home Address:	City:	State:	Zip:

TELEPHONE NUMBERS WHERE PARENT/GUARDIAN CAN BE REACHED IN CASE OF EMERGENCY:

Home Phone Number:	Mother's Work Number:	Father's Work Number:
Other Contact Name:	Relation To Student:	Number:
Other Contact Name:	Relation To Student:	Number:

PLEASE INDICATE BY CHECKING AND/OR EXPLAINIG IF THE STUDENT CURRENTLY HAS OR PREVIOUSLY EXPERIENCED ANY OF THE FOLLOWING:

Allergies to any foods or medications: Yes No	If Yes, explain allergies, reactions and treatment:
Tuberculosis: Yes No	If Yes, list dates of contact with any active case:

Asthma: Yes No Cardiac: Yes No Diabetes: Yes No Rheumatic Fever: Yes No
Hearing Problems: Yes No Vision Problems: Yes No Seizures: Yes No Frequent Dizziness: Yes No
Frequent Fainting: Yes No Convulsions: Yes No Tremors: Yes No

Please explain any Yes answers above:

Does the student take any medication? Yes No	If Yes, for what reason?_____ What is the dosage? _____ How often is medication taken?_____	
Name of Student's Physician:	Physician's Phone Number:	Has student had a physical exam in the past? Yes No

EMERGENGY-MEDICAL CARE

I give permission for my child _____ to be given emergency
(*print student's name*)
medical or surgical management (including diagnostic studies and treatment) at an Emergency Room in the event that a parent or guardian cannot be located.

Please check hospital preference: UTMB___ Other___ Name:_____

_____ _____
Parent/Guardian Signature *Date*