



Ambassadors Preparatory Academy

____ Grade
Home Room Teacher

School Health Services HEALTH HISTORY FOR INCOMING STUDENTS

Please complete in 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 child 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

<input type="checkbox"/> operations	<input type="checkbox"/> frequent headaches	<input type="checkbox"/> dental problems
<input type="checkbox"/> heart disease	<input type="checkbox"/> fainting spells	<input type="checkbox"/> reaction to immunizations
<input type="checkbox"/> kidney disease	<input type="checkbox"/> serious accidents	<input type="checkbox"/> asthma
<input type="checkbox"/> chicken pox	<input type="checkbox"/> allergies	<input type="checkbox"/> seizures
<input type="checkbox"/> frequent behavior problems		

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 child 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

<u>Name</u>	<u>Age</u>	<u>Sex</u>	<u>Grade</u>
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

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:

- | | | |
|-------------------------------------|--|--|
| <input type="checkbox"/> fussiness | <input type="checkbox"/> thumb sucking | <input type="checkbox"/> overactive |
| <input type="checkbox"/> bad temper | <input type="checkbox"/> nail biting | <input type="checkbox"/> very shy |
| <input type="checkbox"/> won't mind | <input type="checkbox"/> speech problems | <input type="checkbox"/> wets bed |
| <input type="checkbox"/> jealousy | <input type="checkbox"/> put things in mouth | <input type="checkbox"/> poor appetite |
| <input type="checkbox"/> nightmares | <input type="checkbox"/> doesn't pay attention | <input type="checkbox"/> 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?

