GREENVILLE AREA SCHOOL DISTRICT

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STUDENT HEALTH HISTORY

STUDENT NAME: _____ Birthdate:_____

Number of Brothers:___ Number of Sisters:____ Child Lives with: _____

A: CHILD DEVELOPMENT HISTORY

1. Did the mother have any illness during pregnancy? __ Y __ N
2. Did the baby arrive on time? __ Y __ N
3. What was the baby's birth weight? _____
4. Did the baby have any trouble while in the hospital? __Y __N
5. Did the baby have any special problems in the first six months? __Y __ N
6. At what age did the child sit alone without support? _____
7. At what age did the child begin to say two or three words together? _____
8. At what age did the child walk alone without support? _____
9. Can the child use the toilet without help? __Y __ N
10. At what age did child stop bedwetting? _____

B: SPECIAL HEALTH NEEDS

1. Has the child ever been hospitalized? __ Y __ N

   If yes Explain: _____

2. Is the child taking medication on a regular basis? __ Y __ N

   If Yes, What: _____

3. Does the child need to take medicine during school? __ Y __ N

   If yes, What: _____ Time of day: _____

4. Is your child allergic to: medication/ insect stings/ latex? __ Y __ N

   If yes, Explain:_____

5. Is your child diabetic? __ Y __ N

6. Has the child had any convulsions/seizures during the past year? __ Y __ N

7. Does your child have any physical limitations? __ Y __ N
   a. Will he/she need any special considerations in school? __ Y __ N
   b. Does your child have any restriction to physical activity? __ Y __ N

   Explain: _____

8. Has your child had a Concussion? __Y __ N
   If Yes, When:_____

9. Has the child had any trouble with the following (please check all that apply)

__ ears	__ joint aches	__ constipation
__ hearing	__ stomachaches	__ diarrhea
__ eyes	__ heart murmur	__ blood disorder
__ wear glasses/contacts	__ urinary problems	__ lead poisoning
__ teeth	__ asthma/wheezing	__ sleeping
__ headaches	__ skin problems	__ allergies

10. Does your child have a special diet or food problems? __ Y __ N

If yes, Explain: _____

_____

11. Please list any other medical concerns: _____

_____

12. Please check any of the following which worry you about your child:

__ disobedient	__ shy	__ stammering/stuttering
__ daydreams	__ sad	__ bedwetting
__ too restless	__ sulky	
__Nightmares	__temper tantrums	
__ feelings hurt easily	__jealous of siblings	
__ selfish in sharing	__ fighting	
__thumb sucking	__purposely destroys things	

C: HEARING AND SPEECH INFORMATION

1. Has your child had ear infections, abscesses, drainage or other problems? __ Y __ N

If yes-explain: _____

_____

2. Has your child had any treatment for their ears? If yes check: __ Y __ N

Tonsillectomy__ adenoidectomy __ tubes __ medication __ lancing's __

3. Does your child's hearing seem to fluctuate? (get better or poorer) __ Y __N

4. Has it ever been suggested that your child had a speech or language problem? __ Y __N

If yes, Explain: _____

_____

5. Does any member of the child's immediate family have a hearing problem? __ Y __ N

If yes, Explain: _____

_____

Are there any health conditions of family members that may affect the ability of the child to function in the classroom.?
