SENECA VALLEY SCHOOL DISTRICT
HEALTH HISTORY (Kindergarten-6th grades)

To Parent/Guardian: The information requested on this form will be of help to the school personnel in understanding the health status for your child and in assisting him/her to receive maximum benefits from the educational program. You may choose not to complete some areas of this history. However, this may limit our awareness of your child's needs.

Student Name: _____ _____ _____
Last First Middle

Date of Birth: _____ / _____ / _____ Telephone Number: _____

Physical Address: _____ / _____ / PA / _____
Street Number Street Name City Zip Code

Name of Father/Guardian: _____

Mother's Full Name: (include maiden): _____

Name of student's Physician: _____ Has your child had a medical examination in the past year? ○ No ○ Yes

Name of student's Dentist: _____ Has your child had a dental examination in the past year? ○ No ○ Yes

A. Pre-Natal Health History

Did the mother have any illness during the pregnancy? ○ No ○ Yes Explain: _____

Did the mother take any medicines or drugs (other than iron or vitamins) during the pregnancy? ○ No ○ Yes

Did the baby come on time? ○ Yes ○ No Explain: _____

B. Developmental History

What was the baby's birth weight? _____ Did the baby have any trouble while in the hospital? ○ No ○ Yes

Did the baby have any special problems in the first six months? ○ No ○ Yes

At what age did the child sit alone without support? _____ At what age did the child walk alone without support? _____

At what age did the child begin to say two or three words together? _____

Can the child use the toiled without help? ○ No ○ Yes If the child has stopped wetting the bed, at what age did he/she stop? _____

C. Family Health History

1. Indicate on the line which family member (parent, grandparent, aunt, uncle, brother, sister, etc) had any of the following diseases:

Allergy _____ Asthma _____ Cancer _____

Diabetes _____ Seizures _____ Heart Disease _____

Nervous Breakdown _____ Tuberculosis _____ Sickle Cell _____

Drug/Alcohol Addiction _____ Vision _____ Anemia _____

Lead Poisoning _____ Hearing/Learning Problems _____

Other inherited or family diseases: _____

2. Family Members (note any special relationship such as step-parent, adopted, foster child, etc)

Relationship	Age	Name	State of Health	Occupation/School	Grade reached in school
Mother					
Father					
Brother(s)					
Sister(s)					

3. Have any members of the family died? (not miscarriages) ○ No ○ Yes

4. Including the child, how many people live in the same house? _____

5. Are there any family problems such as: problems with housing, employment, food, etc? ○ No ○ Yes

D. Health History

1. If the child has had any of the following, please indicate the date:

Bronchitis _____ Chicken Pox _____ Diabetes _____
Malignancy _____ Jaundice _____ Mumps _____
Scarlet Fever _____ Rheumatic Fever _____ Tuberculosis _____
Seizure Disorder _____ Whooping Cough _____
Measles (Rubeola) _____ German Measles (Rubella) _____

Fractures? (Please list bone and date):

_____

_____

Surgeries? (Please list type and date):

_____

_____

Please list any serious accidents:

_____

2. Is your child subject to any of the following? (Please check and explain briefly):

Allergies (specify) _____ Asthma_____

Blood Disorder _____ Bone/Joint/Muscle Problems_____

Ear/Hearing Problems _____ Fainting_____

Frequent Colds _____ Frequent Sore Throat _____

Headaches _____ Heart Problems_____

Intestinal Problems _____ Kidney/Urinary Problems_____

Liver Problems _____ Nosebleeds_____

Seizures _____ Sinus Infections_____

Skin Problems _____ Speech Problems_____

Stomach Problems _____ Visual Impairment_____

List any known serious sensitivity or conditions requiring IMMEDIATE MEDICAL ATTENTION:

_____

Is your child currently under care for any chronic condition?

- ○ No
- ○ Yes Please give the name of the physician if it is different from the family physician: _____

E. Please check mark any of the following things which worry you about your child:

☐ Bedwetting	☐ Feelings easily hurt	☐ Disobedient
☐ Wetting during the day	☐ Wanting too much attention	☐ Lying
☐ Thumb sucking	☐ Wanting too much comfort/support from parent	☐ Selfish in sharing
☐ Stammering/Stuttering		☐ Jealous of siblings
☐ High strung/Easily upset	☐ Day dreams	☐ Fighting with other children
☐ Too Restless	☐ Nightmares	☐ Purposely destroys things
☐ Shy	☐ Temper tantrums	☐ Feeding
☐ Sad/Sulky	☐ Contrary/Stubborn	☐ Bowels

☐ Any other problems not mentioned? Describe: _____

Health history obtained from:

_____ _____

Parent/Guardian Signature Date