

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 toilet 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