School Year _____ **Building** _____
Grade/Teacher _____ **Bus #** _____

CARDINAL SCHOOLS HEALTH HISTORY

(To Be Completed By Parent/Guardian)

****In order that we may better help and understand your child, please complete the following health history as accurately as possible. This confidential information is used to compile a permanent health record.****

Legal Name	Birthdate	Male / Female
Street and Mailing Address		
Father's Name		With Family? Yes No
Mother's Name		With Family? Yes No

HEALTH CONDITIONS (Please check all that apply to this child)

_____ Abnormal Spinal Curvature (Scoliosis, etc.)
_____ Asthma or Wheezing
_____ Birth or Congenital defect_____
_____ Behavior Problem
_____ Bleeder (Hemophilia)
____ Cancer - Type: _____
_____ Car/Motion Sickness
_____ Chickenpox - Date: _____
_____ Chronic Conditions _____
_____ Concern About Relations W/Siblings or Friends
_____ Cystic Fibrosis
_____ Diabetes
_____ Ears/Frequent Infections/Hearing Loss
_____ Eating Disorder
_____ Eczema
_____ Eyes/Amblyopia/Glasses
_____ Headaches - Type: _____
_____ Head Injury/Concussion _____
_____ Heart Disease/Defect- Type: _____
_____ Hepatitis - Type: _____
_____ Kidney Disease - Type _____
_____ Lead Poisoning
_____ Meningitis or Encephalitis
_____ Near Drowning or Near Suffocation
_____ Nose Bleeds
_____ Painful menstruation
_____ Reye's Syndrome
_____ Seizures or Epileps
_____ Sickle Cell Disease
_____ Speech Therapy
_____ Stool Soiling
_____ Substance Abuse (Alcohol, Drugs)
_____ Tics or Tourette Syndrome
_____ Ulcer
_____ Wetting Day / Night

Other: _____ _____

Is your child receiving medical treatment or medication now? Explain: _____

Does your child have any medical or physical problems that the school should know about? Explain: _____

Allergies (Please List & Describe): _____

Expected Reaction & Recommended Treatment: _____

Family Stress (Illness, Death, Separation, Drug/Alcohol): _____

Additional Information **(If medication needed during school - <u>MUST have signed doctor order</u>):**

What medications are given daily? _____

Condition: _____ Frequency: _____

***Do you have other comments or concerns about this child's health, development, behavior, family or home life that you would like the school to be aware of ? If yes, explain briefly.

Date_____ Form Complete by _____ Relaionship _____

To Be Completed For Students K-6

Rev.3/02

Perinatal History:

Did the mother have any usual physical or emotional illnesses during this pregnancy? _____ Yes _____ No

If yes, explain briefly: _____

_____

How old was the mother when this child was born? _____

Was this infant born: _____ Full Term _____ Early _____ Late

Infant's Birth Weight: _____ Did the infant have any sickness or problems while in the nursery? _____ Yes _____ No

If yes, explain briefly: _____

_____

Development History:

Please give the approximate age at which the child:

_____ Sat Alone _____ Crawled _____ Walked Alone _____ Toilet Trained

_____ Dressed Self _____ First Word _____Spoke in sentences

How does this child's development compare to that of other children, such as his or her brothers/sisters or playmates?

_____ About the same _____ Slower _____ Faster

Hearing :	**Yes**	**No**
Has this child been under the care of a Specialist	_____	_____
Last Seen _____ Dr._____		
Do you suspect any hearing problems ?	_____	_____
Does this child turn the TV up louder than others in the family ?	_____	_____
Does this child seem to hear you if you whisper ?	_____	_____
Does this child seem to talk louder than others ?	_____	_____

Vision:	**Yes**	**No**
Has this child been under the care of a Vision Specialist?	_____	_____
Last Seen _____ Dr. _____		
Wears Glasses ____ Reading ___ Distance ___ Full Time		
Do you suspect vision problems ?	_____	_____
Do eyes turn in or out ?	_____	_____
Does this child hold a book at a normal distance ?	_____	_____
Does this child rub eyes a lot or squint ?	_____	_____

Speech:

Has this child ever been in speech therapy ? _____ Yes _____ No

Last seen _____ Where _____

Reason for Speech Therapy _____