

MEDWAY PUBLIC SCHOOLS HEALTH HISTORY

Name _____ Phone _____
Address _____ Phone _____
Mother's name _____ Occupation _____
Father's name _____ Occupation _____
Legal Guardian _____ Child lives with _____

Basic Medical Data

Does your child have any significant past medical story? _____

Any hospitalizations, surgery, serious accidents? _____

Primary Health Care

Provider _____ Phone _____

Does your child have regular dental visits? yes no Date of last visit _____

Current Health Status (use additional space to add comments)

FOOD OR ENVIRONMENTAL ALLERGIES _____
(describe type of reaction and what was done)

ALLERGIES TO BEES OR STINGING INSECTS _____

MEDICATION ALLERGY _____

<input type="checkbox"/> anemia	<input type="checkbox"/> frequent strept throat	<input type="checkbox"/> febrile seizure
<input type="checkbox"/> asthma	<input type="checkbox"/> frequent ear infections	<input type="checkbox"/> seizure disorder
<input type="checkbox"/> bleeding disorder	<input type="checkbox"/> tubes in ears	<input type="checkbox"/> last seizure / type
<input type="checkbox"/> bone or joint disease	<input type="checkbox"/> hearing loss	<input type="checkbox"/> dental problems
<input type="checkbox"/> hearing aids	<input type="checkbox"/> kidney disease	
<input type="checkbox"/> diabetes	<input type="checkbox"/> visual / eye problems	<input type="checkbox"/> tuberculosis
<input type="checkbox"/> headaches or migraines	<input type="checkbox"/> eye glasses	<input type="checkbox"/> chicken pox
<input type="checkbox"/> eczema or rash	<input type="checkbox"/> frequent nose bleeds	date (month / year) _____
<input type="checkbox"/> frequent colds	<input type="checkbox"/> heart condition	
<input type="checkbox"/> any limitations?		

Do you anticipate the need for your child to receive medication during school hours? yes no

If yes, what medication _____

Birth and Early Developmental History

Any complications of pregnancy? _____
(toxemia, gestational diabetes, etc.)

(please circle) Full-Term _____ Premature _____ Normal delivery _____ C-section _____ Twin / triplet _____
identical fraternal _____ #weeks at birth _____

Injury or complications at birth or in early weeks / months of life _____

Milestones

Age at which child: sat alone _____ crawled _____ walked _____ spoke 1st words _____
completed toilet training _____

Number of children in household _____ order of child's birth _____

Was there ever a prolonged period of separation from parents (more than 2 weeks) yes no

Age _____ Explain _____

Current Development (please check the statement that best describes)

Behavior

active prefers quiet play outgoing quiet/shy
 irritable short attention span able to entertain self
 usually follows directions needs directions repeated frequently
 Other issues _____

Sleep habits

sleeps well restless nightmares naps, how long?

Eating habits

feeds self picky eater eats a good variety
 mostly grazes at meals

Elimination

independently attends to toileting has accidents bedwetting

Speech Language

speaks clearly difficulty with certain sounds (describe) _____

additional
comments _____

Self Care

washes / dries own hands
 dresses independently
 able to button / unbutton
 able to zipper
 can put on outerwear independently
 needs some help with outerwear

Motor

holds pencil correctly
 writes and draws
 scribbles
 rides tricycle
 rides two wheeler
 throws/catches ball
 climbs without fear

Social

plays well with one or two children
 plays mostly with siblings
 prefers solitary play
 cries when left with sitter
 tends to "take charge"
 tends to "follow along"
 has attended preschool

I AGREE THAT THIS INFORMATION MAY BE SHARED WITH SCHOOL PERSONNEL AS APPROPRIATE FOR MY CHILD'S SAFETY

Parent / Guardian

Signature _____

Date _____