# SOMERDALE PARK SCHOOL

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## CONFIDENTIAL HEALTH HISTORY

STUDENT NAME:____________________DATE OF BIRTH:__________SEX:____

**PREGNANCY & BIRTH** (Check One)

1. Did mother have any illnesses with this child? ___Yes___No
   If yes,explain______________________________________________
2. Was the baby delivered on the due date? ___Yes___No
   If no, explain______________________________________________
3. Did mother have any difficulties during delivery? ___Yes___No
   If yes,explain______________________________________________
4. Did baby have any difficulties before or after delivery? ___Yes___No
   If yes,explain______________________________________________
5. Did the baby have any breathing difficulties? ___Yes___No
   If yes,explain______________________________________________
6. Was the baby given oxygen? ___Yes___No
   If yes,explain______________________________________________
7. Did the baby have any trouble in the hospital? ___Yes___No
   If yes,explain______________________________________________
8. Did the baby have any trouble feeding? ___Yes___No
   If yes, explain______________________________________________
9. A.What did the baby weigh at birth? ________lbs. _____oz.
   B.What was the baby's length at birth? ________in.

**FAMILY**

1. Are both parents in good health? ___Yes___No
   If no, explain______________________________________________
2. Are there any family members with serious health problems that we should be aware of? ___Yes___No
   If yes, explain______________________________________________

**MEDICATION**

1. Is this student on any type of medication at this time? ___Yes___No
   If yes, please list medication(s), dosage and reason it is being taken_________________________________________
   ____________________________________________________________
   ____________________________________________________________
2. Will student need to take medications during the school day? ___Yes ___No
   If, Yes We will need a prescription from the students physician; please review & print copy of School Medication Policy from school website & have one of the Prescription Medication forms completed by student's physician.

**NUTRITION**

1. Appetite:______Good _______ Fair ________Poor
2. Has child had any unusual gain or loss of weight?___Yes___No
3. Do you consider your child's weight average? ___Yes___No
   If no,explain_______________________________________________

-over-

**INFECTION,ILLNESSES,OTHER PROBLEMS**

Has your child had...

1.more than 6 colds or throat infections in a year?___Yes___No
2.more than 3 ear infections? ___Yes___No
3.any trouble seeing? ___Yes___No
4.their vision tested? ___Yes___No
5.any trouble with their teeth? ___Yes___No
  Date of last exam?_______________
6.any trouble passing their urine? ___Yes___No
7.any trouble moving their bowels? ___Yes___No
8.any trouble sleeping at night? ___Yes___No
  Usual bedtime?________
9.Check any of the following that your child has had.....

___strep infections ___rheumatic fever ___speech impediment
___measles ___headaches ___bed-wetting ___mumps
___blackouts ___poor concentration
___scarletina ___epilepsy ___abnormal movements
___pnuemonia ___vision problems ___temper tantrums
___whooping cough ___Croup ___bronchitis
___Over activity ___uncoordination ___aggressiveness
___chicken pox ___chicken pox vaccine___hearing loss
___Hepatitis B vaccine series ___Fractures of what?_________

10. Has your child had any other diseases? ___Yes___No
    If yes,explain____________________________________________

**ALLERGIES** (Check if Applicable)

___ wheezing ___sinus trouble ___hives
___ Eczema ___Reaction to medicine ___hay fever
___ Asthma ___Reaction to insect bites ___Food

If yes to any of the above, please explain______________________

___________________________________________________________________________
___________________________________________________________________________
___________________________________________________________________________
___________________________________________________________________________

**SUMMARY**

**IS THERE ANYTHING IN REGARD TO YOUR CHILD'S BEHAVIOR OR HEALTH THAT YOU WOULD LIKE TO COMMENT ON?**_________________________________________________

___________________________________________________________________________
___________________________________________________________________________
___________________________________________________________________________
___________________________________________________________________________

May we share this information with your child's teacher?

___Yes ___No Yes, however ________________________________________________

___________________________________________________________________________
___________________________________________________________________________
___________________________________________________________________________

PARENT'S SIGNATURE:______________________ DATE:__________

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