ONTEORA CENTRAL SCHOOL DISTRICT

HEALTH AND DEVELOPMENTAL INFORMATION

Student's Name: _____ Sex: M F

Date of Birth: _____ Place of Birth (City/State/Country):_____

Parents/Guardians: 1. _____ 2. _____

Family Doctor/Health Care Provider: _____ Phone: _____

Family Dentist: _____ Phone: _____

Primary language spoken in the home: _____

Health and Developmental History:

Please describe any problems during the pregnancy with this child:_____

Was this infant premature? ☐ yes ☐ no Birth weight? _____ Type of delivery? _____

Did this infant have any problems at birth (e.g. jaundice)? _____

At what age did this child roll over? _____ sit alone? _____ creep/crawl? _____ walk? _____

say single words? _____ say sentences? _____ complete toilet training? _____.

HEALTH HISTORY		**Please give the date this child has had any of the following:**									
Condition	**Date**	**Condition**	**Date**	**Condition**	**Date**	**Condition**	**Date**	**Condition**	**Date**
Anemia		Chickenpox		Frequent colds/URI		Mononucleosis		Scarlet fever	
Asthma		Diabetes: Type ☐1 ☐2		Heart disease		Nephritis/UTI		Seizure disorder	
Bronchitis		Ear infections		Hepatitis: Type___		Pneumonia		Whooping cough	
Other (explain):				Serious injury (explain):					
				Surgery (explain):					
PPD	Date:	Results:	Date:	Results:	Date:	Results:	Date:	Results:	Lead	Date:	Results:

Medical Conditions: Please check **YES** or **NO** and explain any "**YES**" briefly in the space provided.

Condition:		**Explanation:**
Allergies	YES ☐ NO ☐	_____
Vision	YES ☐ NO ☐	_____
Hearing/Ear Conditions	YES ☐ NO ☐	_____
Asthma/Breathing Problems	YES ☐ NO ☐	_____
Speech Difficulties	YES ☐ NO ☐	_____
Bleeding Problems	YES ☐ NO ☐	_____
Behavior Problems	YES ☐ NO ☐	_____
Seizures/Nerve Problems	YES ☐ NO ☐	_____
Kidney Problems	YES ☐ NO ☐	_____
Diabetes	YES ☐ NO ☐	_____
Eating Problems	YES ☐ NO ☐	_____
Frequent Colds/Sore Throats	YES ☐ NO ☐	_____
Heart Problems	YES ☐ NO ☐	_____
Other	YES ☐ NO ☐	_____

Is your child taking any medications currently? YES ☐ NO ☐

If yes, medication and dosage?_____

Will medication need to be administered at school? YES ☐ NO ☐

Has your child ever had a vision examination? **YES ☐ NO ☐** Has your child ever had a hearing evaluation: **YES ☐ NO ☐**

Does your child wear glasses or a hearing aid? **YES ☐ NO ☐** Reason: _____

Has your child been seen by any of the following Health Care Professionals?

Specialty	Name/Phone Number of Specialist	Date seen	Reason
Allergist			
Audiologist			
Cardiologist			
Endocrinologist			
Ear. Nose, and Throat			
Nephrologist/Urologist			
Neurologist			
Nutritionist			
Occupational Therapist			
Optometrist/Ophthalmologist			
Orthopedist			
Physical Therapist			
Psychiatrist			
Psychologist/Therapist			
Social Worker/Counselor			
Speech Pathologist			
Other			

Comments (please use additional sheet if necessary): _____

_____

If your child has an allergy, please describe what happens when your child has an allergic reaction. Is medication needed to treat this allergy? If so, please list the medication(s): _____

_____

If your child has a chronic illness (e.g. asthma, reactive airway, diabetes) or physical limitations, please describe. Does this condition limit participation in physical education, physical activities, or recess? _____

_____

Is there any other information that the school should know in order to safeguard your child's health? _____

_____

Have there been any recent changes in your child's life? YES ☐ NO ☐ Explain:_____

_____.

Describe anything else concerning the health, behavior, or development of this child which the school should know that might interfere with your child's educational experience:_____

_____.

If sharing any of the above information will enhance your child's academic experience, do you give permission for it to be communicated to the classroom teacher and other appropriate school personnel? YES ☐ NO ☐*

Parent/Guardian Signature:_____ Date_____

*If, in the nurse's professional judgment, the safety or health of your child would be compromised by not sharing specific information with key personnel, the nurse will act to protect your child.