Oakdale Joint Unified School District

STUDENT HEALTH HISTORY

Name_____ School: _____ Date:_____
Last First Middle

Address: _____ City: _____State:_____

Birth date: _____ City of Birth: _____State:_____ County: _____

Parent/Guardian Name(s): _____ Home Phone: _____

MEDICAL HISTORY: Necessary information to assure the health and safety of your child will be shared with appropriate staff.

____tires easily	____Skin condition	____Staph/MRSA	____physical limitations
____Bladder/Kidney Disease	____Hepatitis	____Ear Problems	____Birth defects
____Heart Disease	____Head Injury/concussion	____Bowel concerns	____genetic disorder
____Seizures/Convulsions	____Autoimmune disorder	____Diabetes I or 2	____Asthma
____Weight concerns	____Allergic to Bees	____Speech concerns	____Fainting
____Allergic to food(s)	____Allergic Latex	___Other_____	

Other operations, injuries, or hospitalizations and ages of occurrence: _____
Doctor recommendations for any of the above: _____
Child's Doctor's name: _____ Phone: _____
Is the child under a doctor's care now? Yes____ No____ If Yes ~ Why? _____
Is child taking medication regularly? Yes____ No____ If so, what? _____

Has your child been exposed to tuberculosis? Yes_____ No_____ Had tuberculin skin test? Yes_____ No_____
Has your child ever had a chest X-Ray? Yes_____ No_____

Which of the following have you observed in your child? Please mark all that apply.

____Plays well with others	____Angers easily	____Thumb sucking	____Cries easily
____Shares with others	____Discourages easily	____Nail biting	____Hyperactivity
____Is withdrawn	____Is distrustful	____Bed wetting	____Has fears or worries
____Stumbles or drops things often	____Seeks friends	____Follows instructions	____Anxiety

What behavior management is most effective with your child? _____
What activity (or activities) does your child enjoy most? _____

BIRTH HISTORY

Birth Weight: _____ Length_____ Problems/Complications_____
Did the mother receive prenatal medical care during her pregnancy? Yes____ No____
Was the child full term? Yes____ No ____If "No" please explain_____
Was the birth normal? Yes____ No____ If "No" please explain _____
Were forceps used? Yes____ No____
Was there any breathing difficulty with the infant? Yes_____ No_____ Was oxygen given? Yes_____ No_____
Did the baby go home with the mother Yes_____ No_____ If no please explain _____
How old was the child when he/she began to walk? _____ (Months) Talk? _____ (Months)

EXAMINATIONS

Date of last physical examination: _____
Has child ever been examined by an eye doctor? Yes_____ No_____ If Yes, give date of last exam: _____
Has your child ever been examined by a dentist? Yes _____ No_____ If Yes, give date of last exam: _____
Name of family dentist _____ Phone: _____

IF THERE IS ANY CHANGE IN THE CHILD'S HEALTH, WHICH AFFECTS HIS ABILITY TO TAKE PHYSICAL EDUCATION, OR IF HE/SHE IS PLACED ON A REGULAR MEDICATION, (Educ.Code No. 102020) IT IS THE PARENTS' RESPONSIBILITY TO NOTIFY THE SCHOOL. PLEASE REQUEST FORMS AS NEEDED IF EITHER SITUATION EXISTS OR SHOULD ARISE.

If you have a concern about your child's development and would like a conference with any of the following personnel, please check below and describe your concern.

_____ Nurse _____School Psychologist _____Speech and Language Pathologist

I am concerned about my child's development due to:_____
_____

FAMILY MEMBERS (Immediate - Including Parents):

Name	Gender	Birth Date	Birth Place	Relationship to Child	Occupation or Grade

(List additional members on back)

Signature of Parent or Guardian:_____ Date:_____