Old Trail School

STUDENT HEALTH HISTORY

Student and Family Information:

Student's Name: _____ **Date of Birth:** _____

Current Grade: _____ **Gender:** _____

Parents names: _____

Does the student have siblings? _____

How old are they and what are their names? _____

Developmental History:

Was the child born premature or full term? _____

If premature, how early? _____

Any significant problems during delivery? _____

Please give the approximate age when your child reached the following milestones?

Walked alone _____ Spoke in sentences _____ Was toilet trained _____ Dressed self _____

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

About the same _____ Delayed _____ Advanced _____

Health Conditions:

Please check any that your child has a history of:

___ Allergies
___ Anaphylactic reaction
___ Asthma or wheezing
___ Attention Deficit Disorder
___ Behavior/Emotional concerns
___ Birth/Congenital malformations
___ Blood problems
___ Bone/Joint problems
___ Bowel problems
___ Cancer
___ Chickenpox
___ Cystic Fibrosis
___ Diabetes
___ Ear problems/poor hearing
___ Eczema/skin conditions
___ Eye problems/poor vision
___ Headache (frequent)
___ Heart Disease
___ Hepatitis
___ Juvenile Arthritis
___ Meningitis/Encephalitis
___ Seizures/Epilepsy
___ Sore throat (frequent)
___ Speech difficulties
___ Toothaches/dental problems
___ Urinary tract infections
___ Wetting during day or night

Other _____

Injuries, illness & hospitalizations (please explain): _____

Current Health Care Provider

Physician name: _____ **Phone:** _____

Address: _____ **Fax:** _____

Current Health Needs or Concerns:

Tell us about any current health conditions or concerns: _____

_____

Explain any special assistance your child may need during the school day: _____

_____

Please add any comments or concerns you have about your child's health, development, behavior, family or home life that you would like the school to be aware of: _____

_____

Allergies:

If your child has any food or environmental allergies, please obtain the Allergy Action Plan form from the school clinic for your child's health record.

Allergy	Reaction	Treatment

Medications:

Describe medicine your child takes regularly. If ANY medication must be taken at school, please obtain a Medication Authorization form from the school clinic to be completed by you and your child's doctor.

Medications	Reasons	How often/what time?

Signature of person completing form: _____ **Date:** _____