SYCAMORE COMMUNITY SCHOOLS
Our students. Our future.

PRESCHOOL HEALTH HISTORY FORM

Form must be completed and returned to Symmes Elementary School on or before the first day school for the student named below.

CHILD'S NAME (FIRST, MIDDLE, LAST) :					
SEX: ☐ male ☐ female		BIRTHDATE: month day year			
CHILD'S ADDRESS:					
FATHER'S NAME:		MOTHER'S NAME:			
FATHER'S ADDRESS:		WORK PHONE:		HOME PHONE:	
MOTHER'S ADDRESS:		WORK PHONE:		HOME PHONE:	
PARENT(S) ARE: ☐ Married ☐ Separated ☐ Divorced ☐ Widowed ☐ Single Parent					
WITH WHOM DOES CHILD LIVE? Name		Address			
WHO IS THIS CHILD'S LEGAL GUARDIAN?					
WITH WHOM DOES THE CHILD STAY DURING THE DAY? (NAME OF PERSON & RELATIONSHIP TO CHILD OR NAME OF CARE CENTER)					
IS THIS CHILD NEW TO HAMILTON COUNTY FROM OUTSIDE THE CONTINENTIAL U.S.? ☐ yes ☐ no					
WHAT COUNTRIES HAS THE CHILD LIVED IN DURING THE PAST FIVE YEARS?					

FAMILY HISTORY (please list this child's brothers and sisters)

NAME	BIRTH YEAR	SEX	NAME	BIRTH YEAR	SEX
1.			3.		
2.			4.		

PERINATAL HISTORY

AT WHAT MONTH DID MOTHER BEGIN PRENATAL CARE:		
DID MOTHER HAVE ANY UNUSUAL PHYSICAL/EMOTIONAL ILLNESS DURING PREGNANCY? ☐ yes ☐ no IF YES, EXPLAIN BRIEFLY:		
MOTHER'S AGE AT CHILD'S BIRTH:	INFANT WAS BORN: ☐full term ☐early ☐late	INFANT BIRTH WEIGHT:
DID THE INFANT HAVE ANY SICKNESS OR PROBLEMS WHILE IN THE NURSERY? ☐ yes ☐ no IF YES, EXPLAIN BRIEFLY:		

DEVELOPMENTAL HISTORY

AGE WHEN CHILD: _____ walked alone	_____ was toilet trained	_____ dressed self	_____ spoke first words
THIS CHILD IS USUALLY: ☐ very active ☐ normally active ☐ rather inactive			
CHILD'S DEVELOPMENT COMPARES TO OTHER CHILDREN'S: ☐ about the same ☐ slower ☐ faster			
DO YOU HAVE CONCERNS ABOUT HOW CHILD GETS ALONG WITH OTHER CHILDREN? ☐ yes ☐ no IF YES, EXPLAIN BRIEFLY:			
HAS THE CHILD ATTENDED ANY EARLY INTERVENTION OR PRESCHOOL PROGRAM? ☐ yes ☐ no IF YES, WHERE AND WHEN:			

ALLERGIES - Please list and describe allergies or reactions to:

MEDICINES/DRUGS:
FOODS/PLANTS/ANIMALS/OTHER:
RECOMMENDED TREATMENT IF ALLERGY IS SEVERE:

-OVER-

HEALTH CONDITIONS - Please check any that this child has had:

___	Abnormal spinal curvature *(scoliosis, etc.)*	___	Concern about siblings/ friend relationship	___	Meningitis/encephalitis
___	Allergies or hay fever	___	Cystic Fibrosis	___	Mumps
___	Anemia	___	Diabetes	___	Rheumatic Fever
___	Arthritis	___	Diarrhea/constipation *(chronic)*	___	Rubella *(3-day measles)*
___	Asthma	___	Eczema	___	Seizures/epilepsy
___	Behavior problems	___	Emotional problems	___	Sickle cell disease
___	Birth/congenital malformation	___	Headaches *(frequent)*	___	Skin rashes *(frequent)*
___	Cancer, Type _____	___	Heart disease	___	Stool soiling
___	Chicken pox	___	Hepatitis	___	Throat infections *(frequent)*
		___	Kidney disease	___	Tics/nervous twitches
		___	Measles *(10-day)*	___	Urinary tract infections
				___	Wetting *(daytime/night)*

LIST ANY FOOD SUPPLEMENTS OR MODIFIED DIETS CURRENTLY BEING ADMINISTERED TO THE CHILD:

INJURIES AND ILLNESSES - Please list any surgical procedures, severe injuries or illnesses:

Injuries/Illnesses/Surgeries	Age of Child	Was Child Hospitalized?
		☐ yes ☐ no
		☐ yes ☐ no
		☐ yes ☐ no

LIST CHILD'S CURRENT HEALTH PROBLEMS:

LIST DAILY MEDICATIONS:

LIST FREQUENT, BUT NOT DAILY, MEDICATIONS:

SIDE EFFECTS OF MEDICATIONS LISTED ABOVE:

LIST AND DESCRIBE CHILD'S SPECIAL NEEDS THAT REQUIRE DAILY CARE:

Have any evaluations or treatments/therapy been done with the child? (Indicate below)

	EVALUATIONS		CURRENTLY RECEIVING TREATMENT/THERAPY
	Where	When	Where & By Whom
SPEECH			
PHYSICAL THERAPY			
OCCUPATIONAL THERAPY			
VISION			
HEARING			
COGNITIVE/ABILITY TESTING			
FAMILY COUNSELING			
OTHER			

DOES CHILD RECEIVE BENEFITS FROM BUREAU OF CHILDREN WITH MEDICAL HANDICAPS ? ☐ Yes ☐ No

Has the child ever been to a dentist? ☐ Yes ☐ No (If yes, please provide information below)

DENTIST NAME: DENTIST PHONE:

DENTIST ADDRESS: DATE OF LAST VISIT:

COMMENTS/CONCERNS ABOUT CHILD'S HEALTH, DEVELOPMENT, BEHAVIOR, HOME LIFE:

FORM COMPLETED BY: RELATIONSHIP TO CHILD:

SIGNATURE OF ABOVE PERSON: DATE: