CLINTON PUBLIC SCHOOL

STUDENT COMPREHENSIVE HEALTH HISTORY

(To be completed by Parent/Guardian for the School Nurse. This information is private and will be kept in the School Nurse's office. It will only be shared with staff on a "need to know basis.")

Child's Name_____

Date of Birth_____ **Sex:** _____**Male** _____ **Female**

Names of Parents/Guardians_____

Address_____ **Phone**_____

Name of Doctor_____

Pregnancy, Infancy and Developmental Milestones (If known):
This child is number _____of _____ children in the family from oldest to youngest.
Was this pregnancy considered high risk? If yes, why?
Problems encountered during pregnancy (such as anemia, bleeding, high blood pressure, diabetes, illness/injury, chronic vomiting).
Length of pregnancy: _____ weeks
Birth Weight: _____lbs _____ oz Length _____ inches
Did the baby have any early problems (such as swallowing, sucking, vomiting, crying, allergies)?
Describe your child as an infant:
Sat at _____ months. Walked at _____ months. Played with, not around, others at _____ months. Does your child engage in pretend play with peers?
Said "dada" at _____ months, "mama" at _____ months. Said a simple sentence at _____ months. Talked socially with others at _____ months. Was/is there a stuttering problem? Is speech presently understandable to adults outside of the family?
Toilet training: During the day at _____ months for wetting and soiling.
Personality: Outgoing? _____ Shy?_____ Comments:
Made regular gains in height and weight? If no, please explain:
Any serious illnesses, injuries, hospitalizations?

Disease History	**Year**	**Disease History**	**Year**
Hepatitis		Asthma	
Neuromuscular		Chicken Pox	
Convulsion/Seizure		Diabetes	
Heart Disease		Middle Ear Infections	
Strep Infections		Rheumatic Fever	
Mononucleosis		Lyme Disease	

**********Please complete the reverse side.**********

Current Health Patterns
Describe your child's appetite:
Food allergies?
Does your child eat a wide variety of foods each day?
Unusual weight gain or loss at any time?
Usual snack foods:
Food likes:
Food dislikes:
Usual bedtime:_____ Usual wake-up time:_____ Does he sleep soundly without interruption?
Bedwetting problem?_____ Age_____ Explain: Was a physician consulted?
Is your child active on a daily basis?

Current Health Problems
List problems:
Undergoing care by a physician?_____ Physician's Name_____
Medications currently taking on a regular basis (including over-the-counter):
Drugs taken regularly in the past:

Allergies
Allergic to any drugs? Please list and describe reaction:
Allergic to any foods? Please list and describe reaction:
Allergic to bee stings? Please describe reaction: Is there a family history of bee sting reaction?

Dental History
Name of family dentist:
Date of last examination:

Other
Please list any other issues you would like to make us aware of:

Signature of Parent/Guardian_____ Date_____