CLINTON PUBLIC SCHOOL
STUDENT COMPREHENSIVE HEALTH HISTORY
(To be completed by Parent/Guardian for the School Nurse)

Child's Name_____ Date of Birth_____
Names of Parents/Guardians_____
Address_____ Phone_____

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?
Mother's age during this pregnancy. _____ years
Under a physician's care as of the _____ month.
Medications, including over-the-counter, taken during this pregnancy:
Problems encountered (such as anemia, bleeding, high blood pressure, diabetes, illness/injury, chronic vomiting).
Length of pregnancy: _____ weeks
Length of labor from start of regular progressive contractions: _____ hours
Birth: Head first _____ Breech _____ Forceps used _____ C-Section _____
Drugs used during labor and delivery:
Type of Anesthesia used:
Birth Weight: _____lbs _____ oz Length _____ inches
Apgar scores (If known) #1 _____ #2 _____
Did the baby have difficulty breathing at birth? Was oxygen used?
Did jaundice develop?
Breast fed? Bottle Fed? How long?
Did the baby have any early problems (such as swallowing, sucking, vomiting, crying, allergies)?
Describe your child as an infant:
He/she 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	

Current Health Patterns
Describe your child's appetite:
Does he/ she have any food allergies?
Does he eat a wide variety of foods each day?
Does he take dietary supplements (vitamins, flouride)?
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:

Special Needs (Conditions requiring special school management)

Signature of Parent/Guardian_____ Date_____