



EASTON AREA SCHOOL DISTRICT HEALTH INFORMATION

Name of Child _____ Date of Birth _____ ☐ Male ☐ Female Grade _____
Name of Parents/Guardians _____ Home/Cell phone _____

Hearing Difficulties:

☐ yes ☐ no
☐ tubes _____
☐ hearing aid _____

Speech Difficulties:

☐ yes ☐ no
Prior Speech Therapy _____

Vision Difficulties:

☐ yes ☐ no
☐ glasses
☐ surgery
☐ patching
☐ other _____

Doctor's Name/Clinic _____

Date of last physical exam _____

Dentist's Name _____

Date of last dental exam _____

Eye Doctor _____

Date of last eye exam _____

Name of Insurance _____

☐ My child does not have health insurance at this time.

****IMMUNIZATIONS:** Please attach a current health care provider's copy of your child's immunizations

**Communicable Diseases
Illnesses/Current or Past
Health Concerns:**

☐ **NONE**
☐ ADD/ADHD
☐ Anemia
☐ Arthritis
☐ Asthma
☐ Birth Defects
☐ Bladder/kidney concern
☐ Bleeding Disorder
☐ Bowel concern
☐ Cancer/Leukemia
☐ Chicken pox (Year _____)
☐ Developmental Delays
☐ Diabetes
☐ Emotional/psychological concern _____
☐ Headaches/ ☐ Migraines
☐ Heart concerns
☐ Hepatitis
☐ Inherited/Genetic Diseases
☐ Orthopedic concern
☐ Seizure (date last one) _____
☐ Sickle cell disease/trait
☐ Skin concern
☐ Stomach concern
☐ Thyroid Disease
☐ Tuberculosis (☐ Child/☐ Family Member / Date: _____)
☐ Weight Concerns
☐ Other: (specify) _____

Allergies:

☐ none
☐ bee/insect sting
☐ environmental
☐ food (specify) _____
☐ medicine
☐ milk/dairy
☐ other (specify) _____

What is your treatment _____

Medication: Is your child taking any medication regularly?

☐ yes ☐ no
Name of medicine _____

Reason for medicine _____

Time _____
Dosage _____
Prescribed By _____

Will your child need to take medication in school?

☐ yes ☐ no

If yes, obtain EASD medication form. An adult must deliver medication to the school nurse.

Serious Medical History:

Broken Bones: ☐ yes ☐ no Type/Date: _____

Serious Accidents: ☐ yes ☐ no Type/Date: _____

Head Injury: ☐ yes ☐ no Type/Date: _____

Operations: ☐ yes ☐ no Type/Date: _____

Explain: _____

Developmental History

Child's Birth Weight: _____

Was your child born premature: ☐ yes / ☐ no - If so, how early? _____

Were there any complications during pregnancy or childbirth? _____

At what age did your child:

Walk _____ Say words _____

Sentences _____ Sit Alone _____

Toilet Train _____

Is your child fully toilet trained? ☐ Yes ☐ No ☐ Day / ☐ Night

Does your child have any dietary restrictions? ☐ yes / ☐ no

Does your child have any feeding concerns? ☐ yes/☐ no

Does your child need assistance with dressing / washing himself?

☐ yes/☐ no

Psychological/Social History

Please check if your child displays any of the following characteristics:

☐ Aggressive	☐ Bedwetting	☐ Clumsy	☐ Compulsive	☐ Daydreaming	☐ Defiant
☐ Disobedient	☐ Disrespectful	☐ Excessively Shy	☐ Hyperactive	☐ Immature	☐ Impulsive
☐ Nervous	☐ Oversensitive	☐ Sad	☐ Stubborn	☐ Temper Tantrums	
☐ Thumbsucking	☐ Tics	☐ Other _____			

Comments/Concerns:

Has your child experienced grief/trauma/significant life event? (Explain) _____

Family Medical history / parental concerns _____

Is your family receiving supportive services from any outside agency? (Please List) _____

Other Concerns _____

The above information is accurate and complete to the best of my knowledge. I give permission to share information with appropriate school personnel as necessary.

Parent Signature: _____ Date: _____