FIFE SCHOOL DISTRICT

HEALTH AND DEVELOPMENT HISTORY

Student Name: _____ DOB: _____ Date: _____

Pregnancy

1. Mother's age during this pregnancy_____ Father's age_____
2. Total number of pregnancies_____ This pregnancy was number _____
3. Were any children born with abnormalities? Yes_____ No_____
4. What month was medical care began? _____
5. Concerns during pregnancy_____
6. Did you have any of the following problems during pregnancy?
   a. Bleeding _____ f. Diabetes _____
   b. Injury _____ g. Drugs _____
   c. Illness w/ fever _____ h. Smoking _____
   d. High B/P _____ i. Alcohol _____
   e. Weight loss _____ j. Special diet _____
   Other: _____
   _____
7. Were medications/drugs used during pregnancy? Yes ____ No ____ If yes, please explain:
   _____

Birth

8. Was child born in hospital? YES/NO Where _____
9. What was the approximate length of labor? _____
10. Type of delivery (vaginal, caesarian)_____
11. What was the baby's birth weight? _____lbs. ____ozs. Apgar scores? _____
12. Any concerns/complications during the labor and delivery? Yes____ No ____ If yes, please explain: _____
13. Did this child need any special care in the hospital? Yes ____ No _____ If so, please explain:
    _____
14. Concerns during the first year:
    a. Feeding problems _____ Did you have to change formula/food_____
    b. Allergies _____ Colic _____Diarrhea/Constipation
    c. Trouble gaining weight _____
    d. Growth problems _____
    e. Diagnosed chronic problem _____
    Comments: _____
    _____

Development

15. Were there any health problems identified in the first 3 years? Yes ____ No _____ If yes, please explain: _____
16. At what age did this child (estimate month of age; i.e., 5-7 mos):
    a. Roll over _____ e. Talk _____
    b. Sit up _____ f. Toilet trained _____
    c. Crawl _____ g. Begin school _____
    d. Walk _____
17. Any concerns regarding motor or speech development? Yes ____ No _____ If so, please explain:_____
18. Any concerns regarding your child's behavior at home or at school? Yes____ No ____ If so, please explain: _____
19. Has growth and development been similar to siblings and other children? _____
    _____

Health History

20. Has your child ever had any of the following health problems or issues? **Please mark or circle below*
    _____ **SKIN** (chronic rashes, eczema, allergies)
    _____ **HEAD** (chronic headaches, migraines, concussion)
    _____ **EYE PROBLEMS** (lazy eye, eye surgery, impaired vision, glasses)
    _____ **EARS** (chronic ear infections, hearing loss, tubes, surgery)
    _____ **NOSE and MOUTH** (chronic sinus infections, allergies, tonsillitis, dental problems)
    _____ **CARDIO-RESPIRATORY** (heart problems, cardiac surgery, infections, asthma)
    _____ **GASTRO-INTESTINAL** (chronic diarrhea/constipation, irritable bowel disease, surgery)
    _____ **GENITO-INTESTINAL** (kidney/bladder infections, reproductive issues, bedwetting)
    _____ **MUSCULO-SKELETAL** (impaired balance, sore joints, orthopedic problems, injury)
    _____ **NEUROLOGICAL** (seizures, staring spells, loss of consciousness)
    _____ **ENDOCRINE (**diabetes, hypoglycemic, thyroid, pituitary problems, metabolic disorder)
    _____ **HEMATOLOGICAL** (anemia, blood disorder)
    _____ **INFECTIOUS DISEASES** (mumps, measles, pertussis, tuberculosis)
    _____ **BEHAVIORAL/EMOTIONAL** (attention deficit disorder, depression, anxiety disorder, Alcohol/drug misuse, autism, mood disorder, tantrums, sleeping problems)
    If you marked any of the above, please explain or comment: _____
    _____
    _____
21. Has your child had a serious injury or accident? Yes _____ No _____ If so, please explain:
    _____
22. Has your child been in the hospital or had any operations? Yes _____ No _____ If so, please explain:_____
23. Does your child take any medications? Yes _____ No _____ If yes, name of medication and dosage: _____
24. Name of current physician/health care provider: _____
    Approximate date of last medical examination: _____ Last dental exam: _____

Social and Educational Family and Home

25. Major caretaker: _____
26. People living with child at home: _____
27. Current health or social problems in the home that might affect child: _____
    _____
    _____
28. Has any language other than English been spoken at home? Yes _____ No _____
    Primary language spoke at home: _____
29. Is your child involved with any activities or hobbies? (Please list) _____
    _____
30. What does family see as a concern? _____
    _____
31. What are your expectations? _____
    _____

Comments

32. Please add any comments or information that you feel would help school staff to understand your Child and his/her needs: _____
    _____
    _____

Parent/Guardian Signature: _____ Date: _____