

**SPRINGFIELD PUBLIC SCHOOLS
SPRINGFIELD, NEW JERSEY 07081**

HEALTH HISTORY:

To be completed by parent/guardian of children pre-school - 2nd grade

Child's name _____ Birth date _____ Gender _____

Parent/Guardian #1 _____ Parent/Guardian #2 _____

With whom does the child live? _____ Who is legal guardian? _____

PERINATAL AND DEVELOPMENTAL HISTORY

1. Did the mother have any unusual problems/illness during the pregnancy or the birth, such as breech, forceps, or caesarian delivery?

Yes _____ No _____ if yes, explain briefly:

2. Was the infant born full term _____ early _____ late _____?

3. What was the infant's birth weight: _____

4. Did the infant have any sickness or problems while in the hospital, such as yellow jaundice, blue spells or convulsions? Yes _____ No _____

If yes, explain briefly:

5. Please give approximate age at which the child: sat up alone _____ walked _____
Said single words _____ said sentences _____ was toilet trained _____

6. How does this child's development compare to other children, such as brothers, sisters, or playmates?
About the same _____ slower _____ faster _____

ALLERGIES AND ASTHMA

1. Please list and describe allergies or reaction to:

Medicines / drugs _____

Foods / plants / others _____

Bee or wasp stings _____

2. Recommended treatment if allergy is severe: Allergy Shots? _____

3. Does this child have asthma that has been diagnosed by a doctor?

Yes _____ No _____ If yes, what treatment has been prescribed?

HEALTH CONDITIONS (Please check any that this child has had)

- | | |
|--------------------------------------|------------------------------------|
| _____ CHICKEN POX (WHAT YEAR? _____) | _____ high fevers |
| _____ Diabetes | _____ poor hearing |
| _____ eye problems, poor vision | _____ seizures or epilepsy |
| _____ or crossed eyes | _____ sickle cell disease |
| _____ frequent ear infections | _____ toothaches/dental infections |
| _____ tubes in ears | _____ other? List |
| _____ frequent headaches | _____ lactose intolerance |
| _____ stomach aches | _____ frequent sore throat |

_____ Is your child frequently sick? If yes, please explain: _____

INJURIES, ILLNESS AND SURGERIES

Please list any severe injuries, illness or surgeries:

Injuries, illness, surgeries	age of child	if hospitalized
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

ADDITIONAL INFORMATION:

1. What medications are given daily? _____
2. What medications are given frequently, but not daily? _____
4. This child is usually: very active _____ normally active _____ rather inactive _____
5. Do any family members have long-term illness, such as diabetes or high blood pressure? If so, what?

Do you have any other comments or concerns about this child's health, development, behavior, family or home life that you would like the school to be aware of? If yes, please explain:

Completed by _____ Date _____

Relationship to child: _____

I would like a conference with the school nurse: Yes _____ No _____