



## Child Health and Developmental History

Child's Name: \_\_\_\_\_ MARSS ID (office use only): \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Gender: \_\_\_\_\_ Female \_\_\_\_\_ Male

Parent/Guardian Name (s): \_\_\_\_\_

Person Completing Form: \_\_\_\_\_ Date: \_\_\_\_\_

### **Pregnancy and Birth Information:**

At how many weeks gestation was your child born? \_\_\_\_\_ Birth weight: \_\_\_\_\_

Any problems during pregnancy or birth? \_\_\_\_\_

Is your child adopted? \_\_\_\_\_ Yes \_\_\_\_\_ No If yes, at what age? \_\_\_\_\_

### **Child Health History:**

Please check all that apply to your child and describe:

- Medical Diagnosis: \_\_\_\_\_
- Daily/Routine Medications: \_\_\_\_\_
- Emergency Medications: \_\_\_\_\_
- Allergies (food, environment, medication, seasonal): \_\_\_\_\_
- Follows with specialists: \_\_\_\_\_
- Surgical History: \_\_\_\_\_
- Recent Hospitalizations: \_\_\_\_\_
- Vision Problems: \_\_\_\_\_ Glasses: \_\_\_\_\_ Yes \_\_\_\_\_ No
- Hearing Problems: \_\_\_\_\_ Frequent Ear Infections: \_\_\_\_\_ Yes \_\_\_\_\_ No
- Behavior Concerns: \_\_\_\_\_
- Significant Immediate Family History: \_\_\_\_\_

### **Please check any areas that you have concerns or questions about your child:**

\_\_\_\_\_ Health \_\_\_\_\_ Learning \_\_\_\_\_ Behavior \_\_\_\_\_ Development \_\_\_\_\_ Speech/talking

\_\_\_\_\_ Vision \_\_\_\_\_ Hearing \_\_\_\_\_ Social \_\_\_\_\_ Obtaining Access to Health Care

### **Family Information:**

Has there been any unusual stress in your family within the past year or more that might have an impact on your child?

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Do you have any questions about resources/services available to you through the school district or the community?

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_