BLOOMSBURY ELEMENTARY SCHOOL

Health History

(to be completed by parent)

Student Name:_____ (Nickname):_____Birthdate:_____

Address:_____ City:_____ Phone:_____

Name & Age of Siblings_____

Were there any complications during birth? No ☐ Yes ☐

Describe:_____

How do you feel your child's health is now?

Excellent ☐ Good ☐ Poor ☐

Does your child see a doctor, dentist, psychologist, physical or speech therapist regularly?

Yes ☐ No ☐

If so, how often _____

For what conditions? _____

_____

Does your child take medication regularly? No ☐ Yes ☐

Name of Medication and the reason it is being given:

_____

Has your child had any serious illness, accidents, operations or injuries? *Please describe and give dates*:

Illness: _____Date:_____Description: _____

Accident:_____Date:_____Description:_____

Operation:_____Date:_____Description:_____

Sutures:_____Date:_____ Where: _____

Fractures: _____Date: _____Where: _____

Has your child ever had any of the following? *If so, please fill in the date.*

_____Measles	_____Ear Infections	_____Headaches
_____Scarlet Fever	_____Coxsackie	_____Bronchitis
_____German Measles	_____Strep Throat	_____Tonsillitis
_____Mumps	_____Chicken Pox	_____Asthma
_____Pneumonia	_____Epilepsy	_____Cardiac

Does your child have any allergies? *If so, to what*:

To medicines?_____ Environmental?_____

To foods?_____Insects?_____

At what age did your child perform the following:

sit_____ crawl_____ stand_____

walk_____ speak words_____ sentences_____

Right Handed ☐ Left Handed ☐ Not sure ☐

Have you had any concerns about your child's growth and development?

Yes ☐ No ☐ If yes, explain_____

Does your child have any problem with:

Hearing ☐ Vision ☐ Speech ☐ *Explain below*

Does he or she wear glasses? Yes ☐ No ☐ Hearing aid? Yes ☐ No ☐

Other, please explain:_____

Your child's appetite is: Excellent ☐ Good ☐ Fair ☐ Poor ☐

Is he or she on a special diet at home? _____

Does your child sleep well at night? _____Does he or she nap? _____

Does your child suck his/her thumb? Yes ☐ No ☐ Bite his nails? Yes ☐ No ☐

Is your child able to dress him/herself? Completely ☐ Mostly ☐ Partially ☐ No ☐

Is he or she able to take care of his/her bathroom needs? Yes ☐ No ☐

Does he/she wet the bed? Yes ☐ No ☐

Place an "**X**" on the line between the words which best describes your child:

Happy~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~Sad
Out going~~~~~~~~~~~~~~~~~~~~~~~~~~~~~Shy
Easy going~~~~~~~~~~~~~~~~~~~~~~~~~~~~Nervous
Mature~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~Immature
Separates easily from parents~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~Does not
Plays well with others~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~Plays alone

Has your child attended nursery school? Yes ☐ No ☐

Number of years_____ Name of School_____

Does mother work outside the home? Yes ☐ No ☐

Other care givers besides parents: Yes ☐ No ☐ Who?_____

Has your child ever experienced a severe emotional shock? Yes ☐ No ☐

If yes, please explain _____

(*Examples; auto accident, death, divorce or other upsetting situations*)

Does your child have any strong fears?_____

(*Examples; thunderstorms, dogs, masks, clowns*)

Is there any other information that you wish to share with us?

_____

_____

Thank you so much for your cooperation in completing this form. It will make your child's early school experience a more fulfilling one.

_____ _____

Date Parent/Guardian Signature