Wells-Ogunquit C.S.D.
SCHOOL HEALTH SERVICES
HEALTH HISTORY

PARENT: This information requested is for the school medical record kept for each pupil and is of great help to the school nurse in understanding and helping to safeguard your child's health. Please complete this questionnaire to the best of your ability.

Child's Last Name	First Name	Middle Name	Sex	Birth date

Father's Name	Occupation	Mother's Name	Occupation

With Whom Does Child Live	Address	Telephone

EARLY HISTORY: Injuries or complications at time of birth or during the first year.
(If answer is yes, give a brief explanation.)

a. Length of pregnancy_____
b. Birth Weight_____Length_____
c. Complications during labor_____
d. Need for oxygen_____
e. Need for incubator_____
f. Feeding problem_____
g. Excessive vomiting_____
l. R.H. Problem_____
j. Cyanosis (blue color)_____
k. Jaundice (yellow color)_____
l. Seizures_____
m. Temperature of 103 or above_____
n. P.K.U. Problem_____
o. Other_____

DEVELOPMENTAL HISTORY: Approximate age at which your child first:

1. Rolled over _____
2. Sat alone_____
3. Crawled_____
4. Walked alone_____
5. Dressed Self_____
6. Spoke a three word sentence_____
7. Completed toilet training _____
8. Started to use pencil_____

PAST ILLNESSES: (Answer Yes or No)

1. Allergies (please be specific) _____
2. Asthma _____
3. Diabetes _____
4. Chicken Pox _____ Date _____
5. Scarlet Fever _____ Date _____
6. Strep Throat _____

7. Other illnesses or conditions _____

Explain _____
_____

PLEASE COMPLETE INFORMATION ON REVERSE SIDE

HEALTH STATUS: Does your child have or has he/she ever had any of the following conditions? (Answer yes or no. If yes, please give a brief explanation or reason where indicated.)

1. Frequent headaches _____ age _____
2. Frequent colds _____ age _____
3. Enlarged or infected tonsils _____ age _____
4. Heart condition _____ age _____
5. Bowel problems _____ age _____
6. Frequent urination _____ age _____
7. Frequent stomachaches _____ Reason _____
8. Bedwetting _____ age _____
9. Ear infections _____ age _____
   Ear tubes _____ Still in place? _____ age _____
10. Hearing problem _____ age _____
11. Speech concern _____ age _____
12. Vision problem _____ age _____
    Explain _____ age _____
    Date of last eye exam _____ Glasses _____
13. Seizures _____ age _____
14. Temperature of 103 or above _____ age _____
    Reason _____
15. Accidents _____ age _____
    Explain _____
    _____
16. Other comments: _____
    _____
    _____

A. Does your child receive regular physical checkups? _____ Doctor _____
B. Has your child ever been on prolonged medication? _____ Name of medication _____
   Reason _____
C. Is your child on medication now? _____ Name of medication _____
D. Has your child ever been hospitalized? _____ Age _____
   Reason _____
E. Has your child ever lived apart from the family? _____ How Long? _____ Age _____
   Reason _____
F. Were you ever concerned about any phase of your child's physical, social, or behavioral development? _____ Explain _____
   _____
G. Have you ever been concerned about your child's development relative to a heightened level of activity, distractibility or impulsivity? **If yes to any of these, please explain.** _____
   _____
H. Is there anything further you wish the school to know about your child? _____
   _____
   _____

_____ _____

PARENT'S SIGNATURE **DATE**