ELEMENTARY STUDENT HEALTH AND FAMILY HISTORY QUESTIONNAIRE

Understanding your child's health and family background will help us provide an optimum school program. This information will be part of your child's confidential school record.

NAME_____ SCHOOL_____ DATE_____

Person completing form:_____ Relationship:_____

If your child has a special health problem or physical disability that may require classroom modifications or care at school, please contact a school nurse at 406- 316[illegible].

I. Prenatal/Development History (check items that apply)

A. Birth History:

1. Pregnancy: Under doctor's care in _____ month of pregnancy
   _____Age of mother during pregnancy
   _____Difficulties during pregnancy - circle any that apply: Bleeding, swelling of hands or feet, high blood pressure, low blood count (anemia)
   _____Illness or accidents during pregnancy:_____
   _____Medications during pregnancy:_____
   _____Smoked

2. Labor and Birth
   _____Premature
   _____More than 2 weeks late
   _____Labor longer than 24 hours
   _____Delivered by Caesarean Section
   _____Baby weighed less than 5 pounds
   _____Baby had difficulty breathing
   _____Jaundice (yellow skin)
   _____Days in hospital after birth
   _____Other problems?_____
   _____

B. Development:

1. As an infant, child was:

   _____Very active, napping only briefly
   _____Very quiet, sleeping most of the time
   _____Colicky
   _____Problem with weight gain
   _____Easy to care for

2. Fill in age (months): sat up alone_____, walked alone_____, began talking_____

3. As a toddler, child was:
   _____Very demanding
   _____Very active
   _____Easy going
   _____Awkward
   _____Accident prone

4. As a Pre-schooler, child:
   _____Very active
   _____Mostly played alone
   _____Attended preschool &/or daycare
   Name of School_____
   City_____

PLEASE CONTINUE ON BACK

YES	NO	CONDITION	AGE	DESCRIBE
		DIABETES		
		HEART CONDITION		
		SEIZURE DISORDER (EPILEPSY)		
		ORTHOPEDIC PROBLEM		
		HEAD INJURY		
		CONVULSIONS		
		ANEMIA (LOW BLOOD COUNT)		
		ALLERGY		
		ASTHMA		
		VISION PROBLEM		
		HEARING PROBLEM		
		SPEECH PROBLEM		
		FREQUENT EARACHES		
		FREQUENT COLDS		
		FREQUENT HEADACHES		
		FREQUENT NOSEBLEEDS		
		FREQUENT STOMACHACHES		
		TIRES EASILY		
		OTHER HEALTH PROBLEM		

B. Has your child seen a dentist? _____ YES _____ NO

C. Is your child under a doctor's care now for a health problem? _____ YES _____ NO
Doctor's Name _____ Address _____

D. Is your child taking medication regularly? _____ YES _____ NO
Name of medication _____

E. Any serious illness, accidents, operations? Please explain _____
_____

III. Family History (optional)

A. Years in school:
_____ Mother
_____ Father

B. Have there been any changes in the child's family life that might affect his/her adjustment to school?
_____ Death or serious illness of anyone close to child
_____ Separation from family for more than 2 weeks
_____ Moved in last 2 years, _____ times
_____ Marital separation/divorce
_____ Change in primary caretakers

C. Have there been any occurrences in your child's life or is there something about your child that you think would help us understand him/her? Briefly describe: _____
_____
_____

D. If you think your child has a speech problem, please describe it as best you can: _____
_____
_____
Has child had Speech Therapy ? _____ Where? _____

PLEASE CONTINUE ON BACK