ELEMENTARY STUDENT HEALTH AND FAMILY HISTORY QUESTIONNAIRE

Understanding your child's health and family background assists us in providing an optimum school program. If your child has a health problem that may impact him or her at school please contact the school nurse.

Student Last Name	First Name	Middle	Date of Birth	Age	Gender	Today's Date:

School	Grade	Parent/Guardian name completing this form	Signature

A. BIRTH AND DEVELOPMENTAL HISTORY

1. **PRENATAL** Any illnesses, injuries or other complications during pregnancy? □ no complications
   □ high blood pressure □ preterm labor □ medications taken _____
   □ gestational diabetes □ mother's age >35 □ other explain _____

2. **BIRTH** Any complications during or immediately after birth? □ no complications, full term, healthy newborn
   birth weight _____ □ long labor □ cesarean section □ nuchal cord (around neck)
   □ needed oxygen at birth □ premature @ ____ weeks □ in NICU for _____ days/weeks
   □ jaundice mild __ severe__ □ feeding difficulty _____
   □ Illness or other health problem noted at birth _____

3. **DEVELOPMENT** Any concerns about your child's motor or language development?

Milestone (typical age range)	**Age** (mo or yrs)
Sitting Alone (6 – 11 months)	
Crawling (6 – 10 months)	
Standing Alone (10 – 14 months)	
Walking Alone (11 – 15 months)	
Speaking first words (9 – 13 months)	
Toilet trained (18 – 36 months)	
Putting several words together (18 – 36 months)	

Concerns? _____
_____

4. **BEHAVIOR** Any concerns about your child's behavior?
   □ Frustrates easily □ Eating problems □ Mood swings □ Aggressive or impulsive
   □ Temper tantrums □ Anger □ Hyperactive □ Rigid in routines
   □ Shy □ Often sad □ Poor memory □ Oversensitive to stimuli
   □ Difficulty paying attention □ Difficulty with transitions □ Sleeping problems
   □ Other _____

B. GENERAL HEALTH HISTORY – Check all boxes that apply to your child's health history, describe below:

Past	Current		Past	Current	
		Accident/ injury/broken bone			Emotional concern
		ADHD			Eye/vision problems/glasses
		Asthma/respiratory condition			Frequent colds and flu
		Allergies			Head injury
		Bladder disorder			Heart problem
		Bowel or toileting issues			Kidney problem
		Cancer			Muscular disorder
		Dental concerns			Seizure disorder or history
		Diabetes			Severe Infections
		Blood disorder			Severe headaches/migraine

Other or describe issues: _____

Current medication names, dosages, frequency: _____

Any surgeries/hospitalizations? (type/date) _____

Significant <u>family</u> (other family members) history of health, developmental, or learning problems? _____

Have there been any significant stressors or changes in your child's life? (move, separation, family illness, trauma)

_____

Please add other information that would give us a better understanding of your child and his/her needs:

_____