WASHINGTON TOWNSHIP SCHOOL DISTRICT

Date: ____________________

Please complete the following medical history *and bring it with you to kindergarten registration.* It is a valuable tool for evaluating situations that may develop during the coming years. Thank you for affording us a more complete picture of your child.

~Brass Castle School Nurse ~Port Colden School Nurse

HEALTH HISTORY OF: ______________________________ Date of Birth: ____________________

1. Your Child:

   A. Pregnancy and Birth

   Birth weight: ______ lbs. ______oz. Premature_____ Full term _____

   Describe any problems at the time of birth: ____________________

   Explain anything about the pregnancy of this child which concerned your doctor: ____________________

   ____

   B. Developmental Milestones

   Age of walking *independently*:________ Age of talking: ________ Age toilet trained: ________

   Describe eating habits (include typical snacks): ____________________

   Describe sleeping habits: ____________________

   Describe any difficulties during the pre-school years: ____________________

   C. Physical

   Has/does your child had/have any of the following (Circle appropriate answer. ***If yes, please explain, including dates if applicable***):

Hospitalizations:		
Operations	yes	no
Illness	yes	no
Allergies	yes	no
To: ____________		
Allergic *reactions*:	yes	no
Medications	yes	no
Foods	yes	no
Other __________	yes	no
Asthma	yes	no
On medication	yes	no
Bronchitis/pneumonia	yes	no
Finger/thumb sucking	yes	no
Frequent colds	yes	no
Coordination concerns	yes	no
Bleeds easily/excessive	yes	no
Dental problems	yes	no
Mouth breather	yes	no
Elimination:		
Bed wetting	yes	no
Constipation	yes	no
Diarrhea	yes	no
Daytime incontinence	yes	no
Wears pullups	yes	no
Endocrine/Diabetes	yes	no
Frequent earaches	yes	no
Hearing loss	yes	no
Ear tubes	yes	no
Emotional concerns	yes	no
Headaches	yes	no
Joint pain, swelling, limping	yes	no
Muscular/skeletal/accident prone	yes	no
Frequent sore throats	yes	no
Skin problems/concerns	yes	no
Speech problems/concerns	yes	no
Seizures	yes	no
On medication:______________	yes	no
Vision:		
Problems	yes	no
Sees an eye doctor	yes	no
wears glasses/contacts	yes	no
Worms/parasites	yes	no
Ever passed out/unconscious?	Yes	no
Prone to nosebleeds	yes	no
Tires easily	yes	no
Developmental Disabilities	yes	no
Takes medication daily	yes	no

____

Any further comments: ____________________

____

(OVER>)

D. Inner Self

Describe relationships with parents: ______________________

Describe relationships with brothers/sisters: ______________________

Excessive shyness	yes	no
Temper tantrums	yes	no
Persistent crying	yes	no
Nail biting	yes	no
Able to get along socially with other children	yes	no

2 Your family

A. Family Members:

B. Relationship	Birthdate	Name :
Mother	XXXXXXXX	________
Father	XXXXXXXX	________
Brothers	________	________
	________	________
	________	________
	________	________
Sisters	________	________
	________	________
	________	________
	________	________

C. Physical History

List/discuss any significant physical history: ______________________

Has any family member experienced sudden cardiac death? If yes, please explain: ______________________

Please indicate any medical conditions or chronic illnesses of family members:

Allergies	yes	no	Heart disease	yes	no
Asthma	yes	no	High blood pressure	yes	no
Bleeding disorders	yes	no	Developmental disabil.	yes	no
Vision disorder	yes	no	Mental health illness	yes	no
Cancer	yes	no	Lead poisoning	yes	no
Hearing disorder	yes	no	Seizures	yes	no
Diabetes	yes	no	Tuberculosis	yes	no
Drug/alcohol addiction	yes	no	Kidney disease	yes	no

Please note the relative involved, and any further comments: ______________________

Please provide any further information that you feel would be helpful: ______________________

Parent signature/date: ______________________