HAMILTON TOWNSHIP BOARD OF EDUCATION
DEPARTMENT OF STUDENT SERVICES & PROGRAMS
OFFICE OF SCHOOL HEALTH SERVICES
STUDENT HEALTH HISTORY – ELEMENTARY

It is necessary for school health personnel to have complete health information on your student in order to better understand the child's individual needs, and to develop a permanent health record.

Please read the following and complete all information requested:

School student attended last: _____

Address of school: _____

Phone Number: _____

HEALTH HISTORY AND CURRENT HEALTH STATUS

Kindergarten Enrolled: _____(check) New Student: _____(check)

NAME: _____ **SCHOOL:**_____

DOB: _____ **Male**: _____ **Female**: _____

Name of student's physician: _____ Telephone: _____

Birth sequence of above student: (1st)_____ (2nd)_____ (3rd)_____ (4th)_____ (5th)_____

Numbers of brothers and sisters: _____

Length of Pregnancy: _____ Age of mother during pregnancy: _____

Significant injuries/illness during pregnancy: _____

Drug/Medication/Tobacco/Alcohol use: _____

Type of Delivery: Cesarean _____ Breach _____ Vaginal _____

Describe any complications: _____

_____

Congenital defect (describe): _____

Birth Weight: _____

Jaundice (yellow): No _____ Yes _____

Breast fed: No _____ Yes _____

Bottle fed: No _____ Yes _____

Describe any feeding or eating problems: _____

Was child in incubator? No _____ Yes _____ How long? _____

Developmental:

At what age did child: smile _____ sit alone _____ crawl _____stand alone_____walk alone_____

speak single words _____speak phrases or words with meaning_____feed self_____

At what age did child gain control of: bowel _____ bladder _____

Describe any delays of problems in language development: _____

_____

Does child have any speech handicaps? No _____ Yes _____

Describe: _____

PLEASE RETURN TO THE SCHOOL NURSE

OVER

SCHOOL HEALTH HISTORY – ELEMENTARY

HEALTH ASSESSMENT:

If you answer **YES** to any of the following questions, please describe in the space provided:

Have there been any accidents, significant illnesses?	Yes	No
Has child been hospitalized? If YES, give dates _____	Yes	No
Is there a history of ear infections/fluid in the ear?	Yes	No
Is there a history of hearing problems?	Yes	No
Is there a history of vision problems?	Yes	No
Is there a history of orthopedic problems?	Yes	No
Is there a history of seizures?	Yes	No
Is there a history of surgery?	Yes	No
Is there a history of asthma/allergies?	Yes	No
Is child allergic to any food?	Yes	No
Does child take medications?	Yes	No

Explain any **YES** answers: _____

_____

_____

BACKGROUND

Is child: _____ Right Handed _____ Left Handed

Did child attend nursery school? _____ Yes _____ No

If yes, number of years: _____

Does child have any unusual habits? _____ Yes _____ No

If yes, explain _____

_____

Indicate and explain any present concerns pertaining to your student's health:

_____

_____

Thank you for sharing this information with us. Please be assured that any information of a confidential nature will be treated with respect.

_____ _____ _____

Signature of person giving information Relationship Date

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