PERKINS SCHOOL HEALTH HISTORY

School _____
Enrolled _____
Withdrawn _____

To be completed by parent or guardian

Child's full name _____
LAST FIRST MIDDLE
male _____ female _____ birthdate _____
month day year

Child's address _____
Father's name _____
his address (if different from child's) _____
his work phone _____ his home phone _____ cell # _____
Mother's name _____
her address (if different from child's) _____
her work phone _____ her home phone _____ cell # _____
With whom does child live? _____
name relationship
Who is this child's legal guardian? _____
Please list this child's brothers and sisters:

FAMILY HISTORY

	birth year	sex		birth year	sex
1.			6.		
2.			7.		
3.			8.		
4.			9.		
5.			10.		

This section to be completed by parent or guardian of students Kindergarten thru grade 5 only

PERINATAL HISTORY

Did the mother have any unusual physical or emotional illness during this pregnancy?
yes ____ no ____ If yes, explain briefly _____
How old was the mother when this child was born? _____
Was this infant born: full term ____ early ____ late ____ What was this infant's birth weight? _____
Did the infant have any sickness or problems while in the nursery? yes ____ no ____
If yes, explain briefly _____
_____

DEVELOPMENTAL HISTORY

Please give the approximate age at which this child:

walked alone _____ was toilet trained _____ spoke in sentences _____ dressed self _____

How does this child's development compare to other children, such as his or her brothers/sisters or playmates?

about the same _____ slower _____ faster _____

IMMUNIZATION REQUIREMENTS:

An Immunization record is required upon registration. Immunizations must be completed in accordance with Ohio law by the first day of school attendance. Included in your packet is a copy of current immunization requirements.

I. **HEALTH CONDITIONS** - Please check any that this child has had:

___Abnormal spinal curvature (scoliosis,etc.)
___Allergies or hayfever
___Anemia
___Arthritis
___Asthma or wheezing
___Bedwetting at night
___Behavior problem
___Birth or congenital malformation
___Cancer, type_____
___Chicken pox
___Chronic diarrhea or constipation
___Concern about relationship with siblings or friends
___Cystic fibrosis
___Diabetes
___Eczema
___Emotional problems
___Eye problems, poor vision
___Frequent headaches
___Frequent skin infections
___Frequent sore throat infections
___Heart disease, type _____
___Hepatitis
___Kidney disease, type _____
___Measles ("old fashioned" or "ten day")
___Meningitis or encephalitis
___Multiple ear infections (3 or more)
___Mumps
___Near drowning or near-suffocation
___Nervous twitches or tics
___Poisoning
___Poor hearing
___Pregnancy
___Rheumatic fever
___Seizures or epilepsy
___Sickle cell disease
___Stool soiling
___Substance abuse (alcohol, drugs)
___Suicide attempt
___Toothaches or dental infections
___Urinary tract infection
___Wetting during day

II. **ALLERGIES** - Please list and describe allergies or reactions to:

Medicine/drugs _____
Food/plants/animals/other _____
Recommended treatment if allergy is severe _____

III. **INJURIES AND ILLNESSES** - Please list any severe injuries or illnesses:

Injuries/Illnesses	**Age of Child**	**If Hospitalized (check)**
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Does this child always wear seatbelts in cars? Yes ____ No ____

IV. **ADDITIONAL INFORMATION:**

What medications are given daily? _____
What medications are given frequently, but not daily?_____
This child is usually: very active ____ normally active ____ rather inactive ____
Do you have any concern about how your child gets along with other children?

_____
_____

Do you have other comments or concerns about this child's health, development, behavior, family or home life that you would like the school to be aware of? If yes, explain briefly _____
_____
_____
_____

Completed by: _____
Relationship to child: _____