EAST BRUNSWICK PUBLIC SCHOOLS
Student Services Department
Student Health History

It is necessary that the following confidential information concerning the health history, growth and development of your child be completed. This information is essential for a total understanding of each child as an individual. It also assists in planning the child's individual educational plan.

PLEASE RETURN THE COMPLETED FORM TO THE NURSE AT THE SCHOOL TO WHICH YOUR CHILD IS ASSIGNED.

Date ________________________________School ________________________ Grade _______

Student Name ____Date of Birth _____________

Parent/Guardian Name ____

A. **DEVELOPMENTAL HISTORY**

1. Was pregnancy normal? _________ Number of months_________
2. If mother was ill during pregnancy, state illness, the month in which it occurred, the type of treatment received, drugs and/or medication taken, and the duration of the illness.
   ____
3. Type of delivery (check one): Spontaneous____ Breech____ Caesarean____ Other____
4. Condition of **infant** at birth: Weight:___ Cord around neck:____ Require transfusion:____
   Jaundiced____ Rh or other blood condition____ Require oxygen____ Special nursery:____
   How Long:____ Congenital birth defects:____
   Was child discharged from the hospital with mother?________________________________
5. Age at which your child:
   Crawled_____ Walked Alone_____ Talked_____ Toilet Trained_____ Dressed Self_____
6. Preschool experience? School__________________ How Long? __________
7. Language spoken at home____________________ Does your child speak English_____

B. **FAMILY HISTORY**

1. List information on bothers and sisters

Name	Age	M/F	General Health

2. Is there a history of any of the following diseases in your **immediate family? (List the person)**

   Diabetes__________ Seizures_________
   High blood pressure__________ Asthma/Allergies_________
   Cancer_________ Heart Disease_________
   Mental Illness__________ Substance abuse_________

SLEEP PATTERN

1. How many hours of sleep does your child get each night?_____________________
2. Please circle any problems with the following:
   Falling asleep Staying asleep insomnia sleepwalking bedwetting nightmares

FEEDING AND DIGESTION

1. Is the child's appetite usually good? Yes _____ No _____
2. Do any foods disagree with him/her? Yes _____ No _____
3. Problem with diarrhea or constipation? Yes _____ No _____
4. Does he/she have frequent stomachaches? Yes _____ No _____

INFECTIONS AND ILLNESSES

1. Frequent Colds Yes _____ No _____
2. Hearing Problems Yes _____ No _____
3. Frequent Earaches/Tubes Yes _____ No _____
4. Hearing Test Yes _____ No _____
   If yes, by whom__________________ Results________________________
5. Vision Problems Yes _____ No _____
   Results of eye exam________ Glasses Yes _____ No _____
6. Urinary infections or related problems Yes _____ No _____
7. High Fevers Yes _____ No _____
8. Convulsions Yes _____ No _____
9. Eczema Yes _____ No _____
10. Hives Yes _____ No _____
11. Wheezing Yes _____ No _____
12. Asthma Yes _____ No _____
    Asthma Triggers: ____

Identify substances which might cause allergies:

Foods:____Reaction_______________
Treatment:____
Environmental:________________________________Reaction______________________
Treatment:____

Circle any disease your child has had and indicate age:

Chicken Pox________ Strep________ Lyme's Disease_________
Pneumonia________ Heart________ Neuromuscular_________

List of serious injuries:____Age:____________
Operations:__________Reason____Age:____________
Hospitalizations:______Reason____Age:____________

BEHAVIOR

1. Circle all that apply: Nail biting Fears Thumb Sucking Speech problems Tantrums
   Other:____
2. Does your child have difficulty concentrating and/or short attention span? ___________
   Medication?____
3. What are your child's strengths?____
   ____
4. Do you anticipate any difficulties for your child in school? Please explain:___________________
   ____
5. Please write any other information you wish to share with the school which might be beneficial to your child education.____
   ____
   ____

____

Parent/Guardian Date

HSaae (elem.) Revised 2-2009