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 brothers 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's education._____
   _____

_____

Parent/Guardian Date