

Family History

Please list first and last name of all the child's family members including parents and siblings.

Name	Birthdate	M/F	Health concerns	Attending what school?
1				
2				
3				
4				
5				

Perinatal History

Did the mother have any unusual physical or emotional illness during the pregnancy? <input type="checkbox"/> Yes <input type="checkbox"/> No If Yes, explain briefly.
How old was the mother when the child was born? _____ Birth Weight? Was the infant born: <input type="checkbox"/> Full term <input type="checkbox"/> Early <input type="checkbox"/> Late _____lb. _____oz
Did the infant have any sickness or problems? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, explain briefly.

Developmental History

Please give the approximate age at which this child: Walked alone _____ Spoke in sentence _____ Toilet trained _____ Dressed self _____
How does your child's development compare to other children, (brothers/sisters/playmates)? <input type="checkbox"/> About the same <input type="checkbox"/> Delayed <input type="checkbox"/> Advanced

Allergies

Please list and describe allergies or reactions.

Medications/drugs
Food/plants/animals
Recommended treatment if allergy is severe

Injuries, Illnesses & Hospitalizations

Please list any severe injuries, illnesses or hospitalizations including inpatient and outpatient surgical procedures.

Injuries/Illness/Hospitalization	Date	Age	If hospitalized, please explain

Medication Information

Please describe any medications, prescribed or over the counter, that your child takes daily or frequently

Name of Medication	What is the medication taken for?	How often taken?	What time taken?

Health Conditions

Please check any medical conditions that the child currently has or has had in the past

- | | |
|--|--|
| <input type="checkbox"/> Abnormal spinal curvature (Scoliosis) | <input type="checkbox"/> Hepatitis |
| <input type="checkbox"/> Allergies/hay fever
Allergic to: _____ | <input type="checkbox"/> HIV positive |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Hyperactivity |
| <input type="checkbox"/> Anaphylactic reaction | <input type="checkbox"/> Joint/valve replacement |
| <input type="checkbox"/> Asthma or wheezing | <input type="checkbox"/> Juvenile Arthritis |
| <input type="checkbox"/> Attention deficit disorder (ADD) | <input type="checkbox"/> Kidney disease type_____ |
| <input type="checkbox"/> Behavior problem | <input type="checkbox"/> Lead exposure |
| <input type="checkbox"/> Birth or Congenital malformation | <input type="checkbox"/> Measles (10 day) |
| <input type="checkbox"/> Cancer type_____ | <input type="checkbox"/> Meningitis or Encephalitis |
| <input type="checkbox"/> Chicken pox when_____ | <input type="checkbox"/> Mumps |
| <input type="checkbox"/> Chronic diarrhea or constipation | <input type="checkbox"/> Mutism |
| <input type="checkbox"/> Chronic ear infections | <input type="checkbox"/> Near-drowning/Near suffocation |
| <input type="checkbox"/> Concern about relation with siblings of friends | <input type="checkbox"/> Nervous twitches or tics |
| <input type="checkbox"/> Cystic Fibrosis | <input type="checkbox"/> Pneumonia |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Poisoning |
| <input type="checkbox"/> Eczema/Chronic skin conditions | <input type="checkbox"/> Rheumatic fever |
| <input type="checkbox"/> Emotional problems | <input type="checkbox"/> Seizure disorder/Epilepsy |
| <input type="checkbox"/> Eye problems, poor vision | <input type="checkbox"/> Sickle Cell Disease |
| <input type="checkbox"/> Frequent headaches / Migraines | <input type="checkbox"/> Speech difficulties |
| <input type="checkbox"/> Frequent sore throats | <input type="checkbox"/> Stool Soiling |
| <input type="checkbox"/> Heart disease type_____ | <input type="checkbox"/> Toothaches or dental problems |
| <input type="checkbox"/> Hearing loss | <input type="checkbox"/> Urinary tract infections |
| <input type="checkbox"/> Other _____ | <input type="checkbox"/> Wetting during the day or night |

Behavioral History

The child is usually: Very active Normally active Rather inactive

Has your child ever been violent or acted out in the following manner towards adults or children?
 Hitting Kicking Biting Fighting Scratching

Do you have any concern about how your child gets along with other children?
 Yes No If yes, please explain _____

Please add any comments or concerns you have about your child's health, development, behavior, family, or home life that you would like the school to be aware of. _____

Is this student enrolled in special education course? Yes No

2012-13 School Year

To enter Kindergarten, the child must have: 5 DPT; 4 Polio; 3 HBV; 2 MMR; 2 Varicella Evidence of immunization must be received upon registration for School.

IMMUNIZATIONS					
TYPE	DATE MO/DAY/YR				
DTaP DPT or DT *					
DT/Td*					
POLIO **					
MMR					
HEPATITIS B (HBV)					
VARICELLA****					
HIB (prior to age 5 only)					
TUBERCULIN TEST***					
ROTA VIRUS (given @ 2-4-6 mos., not after 12 months)					
OTHER					

* The requirement of 5 DTaPs if the fourth dose was given before the fourth birthday will only apply to students entering kindergarten. Grades 7-9 need one dose of Tdap or TD vaccine prior to entry into school.
 ** The requirement of 4 doses of any combination of OPV or IPV, the final dose must be administered on or after the 4th birthday regardless of the number of previous.
 *** Only students that are from, or have traveled to high risk countries must have tuberculosis testing within ninety (90) days. .
 **** K-2 must have two doses of varicella; Gr 3-6 must have one dose administered on or after first birthday.

Parent/Guardian Signature: _____ Date: _____

KMS 2.17.2012