

BELLEVILLE HENDERSON CENTRAL SCHOOL DISTRICT
P.O. BOX 158
BELLEVILLE, NEW YORK 13611

HEALTH HISTORY

Name of Child _____

Address _____ Phone _____

Date and Place of Birth _____

Father's Name _____

Father's Employment _____ Phone _____

Mother's Name _____

Mother's Employment _____ Phone _____

Name and Phone of Person to contact if parent is unavailable and child is ill

Is your child presently taking any medication: Yes _____ No _____

If yes, please list here _____

Name of Family Physician or Pediatrician _____

1. Have you ever suspected that your child may have a vision problem? _____

2. Has your child ever had his/her vision tested other than in school?

If yes, what were the results? _____

3. Does your child wear glasses? _____ All the time? _____ Just for reading? _____

3. Has your child ever had hearing difficulties? Yes ____ No ____ If yes, please
describe _____

4. Has your child ever had his/her hearing tested other than in school? If yes, where and
results? _____

5. Has your child ever had ear infections? _____ How many times a year? _____

Were antibiotics given each episode? _____ Has your child had "tubes" in his/her ears? _____

6. Has your child been hospitalized at all since birth? _____
If so, please give dates and reasons _____
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7. Has your child had any other serious illnesses or injuries? _____
If so, please list _____

8. Has your child ever seen a dentist? _____ Name of Dentist _____

9. Does your child have any allergies? _____ If yes, please list _____

Please describe allergic response _____

Does your child require an Epi -Pen _____

DISEASE HISTORY

Please check appropriate blanks if your child has had any of the following:

Measles _____ Mumps _____ Seizure Disorder _____ Chickenpox _____

Croup _____ Diabetes _____ Tonsillitis _____ Other Throat Infections _____

Frequent Headaches _____ Frequent Colds _____ Convulsions with: With High

Fever _____, Accident _____, No Apparent Cause _____ Fever over 105 _____

Whooping Cough _____ German Measles _____

Is your child presently being treated for any illness or injury? _____

Please describe _____

Please describe any dietary restrictions (religious or medical) your child may have _____

Please be aware that any special dietary substitutions require a note from your family physician.

PRESENT DIFFICULTIES (check only if applies)

Asthma _____

Frequent Nightmares _____

Frequent Headaches _____

Bed Wetting _____

Frequent Stomach Aches _____

Trips Easily _____

Frequent Leg Pain _____
Overactive _____
Excessive Eye Blinking _____
Short Attention Span _____
Frequently Hurts Self _____
Unexplained Temper Tantrums _____

Poor Eye/Hand Coordination _____
Often Runs Into Things _____
Trouble With Stairs _____
Other – Describe _____

Are there factors within the home which may be having an affect on your child's performance in school? (for example: recent death, frequent moves, separation/divorce, birth of sibling) _____

Does your child have any other problems not previously mentioned? _____

Parent Signature

Date