

BELLEVILLE HENDERSON CENTRAL SCHOOL DISTRICT

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 \_\_\_\_\_

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 Headaches \_\_\_\_\_  
Frequent Stomach Aches \_\_\_\_\_

Frequent Nightmares \_\_\_\_\_  
Bed Wetting \_\_\_\_\_  
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