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 ______________________________

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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