ROXBURY TOWNSHIP SCHOOLS – ELEMENTARY HEALTH HISTORY

Child's Name______________________________________Sex___Birthdate_________________

Address____Phone____________________

____S.S. #____________________

Mother's Name______________________________Father's Name__________________________

Child Lives With: ______Mother _____Father ______Both ______Guardian

Names & Ages Of Siblings:____

____

____

School Last Attended__________________________Address________________________________

Physician:____Phone____________________

Perinatal History

Birthweight_________Length_____________

Complications of Pregnancy______________
Of Delivery____________________________

Gestation/Prematurity___________________

Birth Defects___________________________

Breathing Problems_____________________

Feeding Problems_______________________

Behavior During Infancy_________________

Developmental History

At what age did your child:
Sit__________Crawl________Stand________
Walk________Talk_________Feed Self_____

Age Toilet Trained______________________

Hand Preference________________________

Habits__________________________________

PLEASE USE BACK FOR ADDITIONAL INFORMATION

Placement: Grade_______________

Teacher________________________________

Registration Date:_________________

Starting Date_____________________

MEDICAL HISTORY AND OTHER HEALTH INFORMATION

Has your child ever had any of the following:

No	Yes		No	Yes	
___	___	Lyme Disease	___	___	Anemia
___	___	Hepatitis	___	___	Bladder/Kidney Infections
___	___	Neuromusc. Dis.	___	___	Bronchitis/Chronic Cough
___	___	Asthma	___	___	Concussion
___	___	Chickenpox (list date)	___	___	Eye Problems
___	___	Convulsive Dis.	___	___	Frequent: Colds/Sore Throats
___	___	Diabetes	___	___	Headaches
___	___	Encephalitis	___	___	Nosebleeds
___	___	Heart Disease	___	___	Stomach Aches
___	___	Meningitis	___	___	Hearing Loss (under care?)
___	___	Mononucleosis	___	___	Hernia
___	___	Otitis Media	___	___	High Fever (over 104°)
___	___	Pneumonia	___	___	Leg/Joint Pain
___	___	Rheumatic Fever	___	___	Skin Problems
___	___	Strep Infection	___	___	Scarlet Fever
___	___	Tonsillitis	___	___	Wears Glasses
___	___	Tuberculosis	___	___	Frequent Ear Infections

Does your child have an allergic reaction to:

Foods______________Medicine________________________Immunizations_____________

Bees_________Other____

Please Explain:____

____

Is your child taking any medication?_______If yes, please indicate the reason/name/dosage/ frequency

____

____

Has your child had:

Serious illness/serious injury/broken bones (Date and Explanation):___________________

____

____

Hospitalizations/Operations (Date and Explanation):________________________________

____

____

Dizzy Spells/Fainting/Blackouts/Unconscious (Date and Explanation):________________

____

____

Do you believe your child should be able to take regular Physical Education__________________

If not, why?____

Is there any further health information that might affect your child's education?_______________

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Date_____________________Parent/Guardian Signature_________________________________