School District of the Chathams

School Health Services

Student Health History

Student Name (last ,first ,middle)_____ _____ _____

o M Grade _____ DOB____/_____/_____

o F Home phone ( ) _____

Home Address_____

Parent 1_____ **Employer** _____

Parent 2_____ **Employer** _____

Sibling: _____ DOB:_____ Sibling: _____ DOB:_____

Sibling: _____ DOB:_____ Sibling: _____ DOB:_____

Physican's Name_____**Phone**_____

Dentist's Name_____ **Hospital** _____

Medications taken daily or "as needed":_____

Please check those that apply and indicate year of onset

	Allergies		Convulsive Disorder		Lyme Disease		Scarlet Fever
	Arthritis		Cystic Fibrosis		Measles Mumps Rubella		Strep/Tonsillitis
	Asthma		Down's Syndrome		Meningitis		Tuberculosis
	Auditory Issues		Ear Infections		Menstruation		Urological Problems
	Celiac Disease		Fractures		Mental Health Issues		Vision/Hearing/ Speech Issues
	Cerebral Palsey		Gastrointestinal Problems		Neuromuscular Disease		Surgeries
	Chicken Pox		Heart Disease		Nosebleeds		
	Chron's Disease		Irritable bowel syndrome		Pneumonia		
	Concussion		Kidney /Bladder Disease		Rheumatic fever		

Name/address of last school attended_____

Grade at previous school_____ **Phone**_____

Please provide any other information that would be helpful in caring for your child at school including a description of health challenges that may require special care at school (Asthma, Allergies, Diabetes, Seizures, Hearing or Vision needs, etc.)

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_____

Parent Signature_____ **Date**_____

*Please complete for student in **Pre-K to Grade 3** only:*

Birth History

Was pregnancy normal _____

Was delivery normal _____

Birth Weight _____lbs _____oz

Early Development

Activity Level: Underactive ____ Normal_____ Overactive_____

Age of attainment of developmental milestones

Sat alone_____ Crawled_____ Walked_____ Talked_____

Toilet trained_____

Does your child do most things with right or left hand? _____