MANCHESTER BOARD OF EDUCATION

STUDENT HEALTH / DEVELOPMENTAL HISTORY

DATE: _____

PLEASE PRINT

NAME OF CHILD: _____ SEX: _____
(Last) (First) (Middle)

ADDRESS: _____ PHONE: _____

PLACE OF BIRTH: _____ D.O.B. _____ VERIFICATION OF BIRTH: _____

FATHER'S NAME: _____ MOTHER'S NAME: _____

GUARDIAN: _____

CHILD LIVES WITH: _____ NUMBER OF CHILDREN IN FAMILY: ____

NAME (First & Last)	AGE	NAME (First & Last)	AGE
_____	____	_____	____
_____	____	_____	____
_____	____	_____	____

CHILD'S PHYSICIAN:
NAME: _____
ADDRESS: _____
PHONE: _____

CHILD'S DENTIST:
NAME: _____
ADDRESS: _____
PHONE: _____

WHAT DOES YOUR CHILD ENJOY DOING? _____

_____

DESCRIBE YOUR CHILD IN ONE SENTENCE: _____

_____

HAS YOUR CHILD HAD A PRE-SCHOOL EXPERIENCE? _____ WHERE? _____

HAS YOUR CHILD RECEIVED SERVICES FROM AN ORGANIZATION SUCH AS MANCHESTER PUBLIC HEALTH NURSING, NEWINGTON HEARING CLINIC, CHILD GUIDANCE, ETC.? _____

_____

HOW DOES YOUR CHILD REACT IN NEW SITUATIONS? _____

_____

HOW DOES YOUR CHILD RESPOND TO MEETING NEW PEOPLE? _____

_____

HAVE THERE BEEN ANY BIG CHANGES IN YOUR CHILD'S LIFE DURING THE PAST YEAR? _____

_____

BIRTH WEIGHT: _____lbs. _____ oz. LENGTH: _____

	YES	NO	EXPLAIN IF YES
1. Were there any illnesses during pregnancy?			
2. Was there consumption of alcohol, drugs or smoking during pregnancy?			
3. Were there any problems during labor or delivery?			
4. Was your child premature?			
5. Were there any problems with child after delivery?			
6. Did your child double his/her birth weight by age 1?			
7. Were there any problems the first year?			
8. Has your child ever had an accident or serious illness?			
9. Has your child ever been admitted to the hospital?			
10. Has your child had an operation?			
11. Has your child had any broken bones or serious burns?			
12. Has your child had a head injury or been knocked out?			
13. Has your child ever taken medicines or poisons accidentally?			
	YES	NO	EXPLAIN IF NO
14. Did your child walk by 18 months?			
15. Did your child speak single words by age 1?			
16. Did your child speak in sentences by age 3?			
17. Do you understand most of your child's speech?			

SYSTEM REVIEW

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1. Is your child allergic to anything?			
2. Does your child have asthma?			
3. Has your child ever had an unusual reaction to an immunization?			
4. Does your child eat anything that is not food (starch, paint, dirt)?			
5. Does your child take medication regularly?			
6. Does your child have trouble seeing; or does he/she squint or have crossed eyes?			
7. Does your child wear glasses ir is he/she supposed to wear glasses?			
8. Does your child have frequent ear infections?			
9. Does your child favor one ear or seem to have trouble hearing?			
10. Does your child have a persistently runny or stuffy nose?			
11. Does your child breathe through his/her mouth?			
12. Does your child have frequent colds, coughs or sore throats?			
13. Does your child tire easily?			
14. Does your child have frequent stomach pain? Vomiting? Diarrhea? Constipation?			
15. Does your child wet or soil his/her pants?			
16. Does your child have any pain or weakness with his/her arms, legs, or does he/she limp?			
17. Does your child complain of frequent headaches?			
18. Does your child have trouble sleeping?			
19. Does your child have skin rashes?			
20. Does your child have any problems with his/her teeth or gums?			
21. Does your child wear any dental appliances?			
22. Are there any other medical problems with your child?			

FAMILY HEALTH HISTORY

1. A child's family includes parents, brothers and sisters, grandparents, aunts, uncles and cousins. Please check if any of the following have occurred in the family and, if so, to whom.

		WHO
____	Allergy (specify)	_____
____	Asthma	_____
____	Blood Diseases	_____
____	Diabetes	_____
____	Hearing	_____
____	Heart Disease	_____
____	Hypertension	_____
____	Learning Disability	_____
____	Rheumatoid Arthritis	_____
____	Seizure Disorder	_____
____	Speech	_____
____	Tuberculousis	_____
____	Other	_____

2. Please list any other information concerning the child's health which you feel would be helpful to the school:

_____

_____

_____

3. Do you have any other concerns about your child as he/she starts school?

_____

_____

_____

4. Please check any of the following areas you would like to see improved by your child:

____ Feeding
____ Toileting
____ Approaching People
____ Paying Attention
____ Controlling Temper
____ Walking or Moving
____ Sitting Still
____ Thumbsucking
____ Playing
____ Listening
____ Understanding Speech
____ Functioning Independently
____ Following Directions
____ Talking
____ Getting Along With Others

Explain: _____

_____

Signature of Parent/Guardian: _____ Date: _____