PENNSBURY SCHOOL DISTRICT
FALLSINGTON, PENNSYLVANIA

SCHOOL _____

IMMUNIZATIONS AND MEDICAL HISTORY REPORT

Male ☐
Female ☐

Child's Name _____ Birthdate _____

Address _____ Parent/Guardian _____

_____ Telephone _____

SPECIAL HEALTH NEEDS (Circle Yes or No)

1. Has the pupil ever had any serious illness or operations? No Yes
   What _____ When _____
2. Is the pupil going to a hospital, clinic, or doctor now? No Yes
   What for _____ When _____
3. Apart from vitamins, is the pupil taking any medications? No Yes
   What _____ What for _____
4. Does the pupil need to take any medicine, tablets or drugs at school? No Yes
   What _____ What for _____
5. Is the pupil allergic to anything, such as foods, plants, insects, drugs? No Yes
   Describe reaction _____
6. Has the pupil had any convulsions (fits, seizures)? No Yes
   How many _____ At what age _____ Treatment _____
7. Does the pupil need a special diet or have any food problem? No Yes
   Give details _____
8. Does the pupil have any special health needs or problems the school should know? No Yes
   Give details _____
9. Has the child had any other illnesses, accidents, or broken bones? No Yes
   When _____ What was the problem _____

PRE-NATAL HEALTH HISTORY (Circle Yes or No)

1. Did the mother have any illness during the pregnancy? No Yes

   Was the mother hospitalized during the pregnancy? No Yes

PRE-NATAL HISTORY . . . (Continued)

2. Did the mother take any medicines or drugs (other than iron or vitamins) during the pregnancy? No Yes

3. Did the baby come on time? If not, early _____ how late _____ No Yes

DEVELOPMENTAL HISTORY (Circle Yes or No)

1. What was the baby's birth weight? _____
2. Did the baby have any trouble while in the hospital? No Yes
3. Did the baby have any special problems in the first 6 months? No Yes
4. At what did the child sit alone without support? _____
5. Did the child creep or crawl before walking? No Yes
6. At what age did the child walk alone without support? _____
7. At what age did the child begin to say two or three words together? _____
8. Can the child use the toilet without help? No Yes
9. Has the child stopped wetting the bed? No Yes
10. Does he/she follow simple directions? No Yes
11. Does he/she stay with a task for a reasonable length of time? No Yes
12. What hour does he/she go to bed? _____
13. Does he/she regularly take a nap? _____
14. Does he/she usually dress themselves without assistance? No Yes
15. Can he/she put their shoes on the proper feet? No Yes Sometimes
16. Can he/she dress without assistance? No Yes Sometimes
17. Is he/she consistently left or right-handed? Left Right Neither
18. Check any of the following which apply to your child at present:

    Thumb or finger sucking _____ Excessive story telling _____ Fear of the dark _____

    Bad dreams _____ Extremely shy _____ Undue anxiety _____

    Anything else? _____

19. Have any members of your family had trouble with reading or spelling? No Yes

20. Does your child appear eager to start school? No Yes

21. Use the space below for any additional information you feel we should know:

_____

_____

_____

_____

_____

HEALTH HISTORY (Circle Yes or No)

1. Has the child had chicken pox? No Yes

2. Has the child had more than six colds or throat infections with a fever in a year? No Yes

3. Has the child had any trouble with ears or hearing? No Yes
   Please explain: _____

4. Does the child presently have tubes in ears? No Yes

5. Has the child had any trouble with eyes or seeing? No Yes
   Please explain: _____

6. Has the child had any trouble with teeth? No Yes

7. Has the doctor ever said the child had a heart murmur? No Yes

8. Does the child have any skin problems? If yes, please explain No Yes
   _____

9. Does the child seem to have trouble breathing through the nose? No Yes

10. Does the child snore at night? No Yes

11. Has the child ever had swelling of any joints or limping? No Yes

12. Has the child ever eaten paint or plaster or anything else which is not food? No Yes
    Please explain: _____

13. Has the child ever had an asthma attack? No Yes

FAMILY MEMBERS Please list all people who live in the house with the child. (NOTE: Any special relationship such as step-parent, adopted, foster-child, etc.)

RELATIONSHIP	AGE	NAME	STATE OF HEALTH	OCCUPATION OR SCHOOL	GRADE REACHED IN SCHOOL
MOTHER					
FATHER					
BROTHERS					
SISTERS					

FAMILY HISTORY (Circle Yes or No)

1. Circle any of the following diseases that this child's parents, grandparents, aunts, uncles, brothers, sisters have had:

   Allergy asthma cancer drug or alcohol addiction diabetes

   heart disease nervous breakdown seizures tuberculosis

   lead poisoning sickle cell vision hearing learning problems

   anemia other inherited or family diseases.

2. How many different houses has this child lived in? _____

3. Is there another language spoken in your home? No Yes
   What language? _____

4. Does your child speak another language? No Yes
   What language? _____

5. Do both parents speak English? Father No Yes

   Mother No Yes

6. Does anyone in the household smoke? No Yes

7. When at home does your child have other children to play with? No Yes

FAMILY HISTORY . . . (Continued)

8. Have there been any circumstances in your child's life that you feel were hard for him/her that might help us understand him/her better?

_____

_____

_____

_____

_____

9. What does your child do when he/she is stressed? (sucks thumb, gets angry, pouts, refuses to talk, etc.) other

All kindergarten students are required to have dental and physical exams.

Please check your choice of Doctor and Dentist.

I wish _____ Family Doctor or _____ School Doctor to examine my child.

I wish _____ Family Dentist or _____ School Dentist to examine my child.

Parent Signature _____

Date _____