ITHACA CITY SCHOOL DISTRICT
HEALTH HISTORY

Today's Date __________________ Home Phone# _______________________________

Pupil's Name ____ Birth date __________________

Male __ Female __ Birthplace (city, state) ____________________________ Birth weight _________________

Address ______________________________________ City __________________________ Zip __________

Cell# _____________________________
Parent/Guardian (name) ___________________________________ Work Phone# _______________________
Cell# _____________________________
Parent/Guardian (name) ___________________________________ Work Phone# _______________________

Child lives with: Parent ____ Parent ___ Both ___ Guardian(s) _______________________________________
Other ___ Name: _________________________________ Relationship _________________
Best contact #_______________________ Work or Cell Phone# _______________________

Previous school attended: ___________________________________ Address: __________________________
City _______________________________________ State _______ Zip _________
Pre-school attended? ____ Name of school ____

Has your child ever attended an Ithaca School? Yes___ No___ Name of School __________________________

Doctor ____ Date of last exam _______________

Dentist ____ Date of last exam _______________

<u>Names</u> and <u>birth-dates</u> of other children living in the home:

Procedure for Emergency Health Care

Please fill in the names of two nearby relatives or friends who can be contacted in the event of your child's illness or injury at a time when you are difficult to locate.

1) Name ____ Daytime phone ______________________
Address ____
2) Name ____ Daytime phone ______________________
Address ____

PLEASE COMPLETE THE MEDICAL HISTORY ON THE BACK

4/2014

HEALTH HISTORY

Child's Name: ____ Birth Date: ______________

Please answer the following questions, and explain all "yes" answers below: Feel free to circle specific information.

1) Has your child had an illness or injury since his/her last physical?………………………………...yes___ no ___
2) Does your child have an ongoing or chronic illness?……………………………………….. yes___ no ___
3) Has your child ever been hospitalized?…………………………………………………. yes___ no ___
4) Has your child ever had surgery? What & when? ________________________________ yes___ no ___
5) Does your child take any prescription or nonprescription medications? ___________ Vitamins? _____ Fluoride? ______ yes___ no ___
6) Does your child have any allergies (for example: pollen, medicine or food)?…………………………..yes___ no ___
7) Has your child been stung by a bee or wasp?……………………………………………..yes___ no ___
   What was the reaction to the sting? Redness?____ Swelling? ____ Breathing difficulties? _____
   Does your doctor prescribe emergency medication for stings? yes___ no ___
8) Does your child ever get a rash or hives?…………………………………………………. yes___ no ___
9) Has your child had chicken pox?…………………………………………………………. yes___ no ___
10) Has your child ever fainted or been dizzy during exercise?…………………………………… yes___ no ___
11) Has your child had chest pain during or after exercise?…………………………………… yes___ no ___
12) Have you been told your child has a heart murmur, or other heart problems?…………………….. yes___ no ___
13) Have you been told your child has high or low blood pressure?…………………………….. yes___ no ___
14) Does your child get frequent or severe nose bleeds?……………………………………… yes___ no ___
15) Does your child have problems with his/her bladder or kidneys?……………………………… yes___ no ___
16) Does your child have problems with constipation or diarrhea?……………………………… yes___ no ___
17) Does your child have any skin problems (for example: itching, rashes, acne, warts, fungus or blisters)?………… yes___ no ___
18) Has your child ever had a head injury or concussion?……………………………………….. yes___ no ___
19) Does your child ever get headaches?………………………………………………….. yes___ no ___
20) Has your child ever had a seizure?……………………………………………………... yes___ no ___
21) Has your child ever complained of numbness or tingling in arms or legs, hands or feet?……………... yes___ no ___
22) Does your child have asthma or reactive airway disease?………………………………….... yes___ no ___
23) Does your child use an asthma medication inhaler or nebulizer?……………………………… yes___ no ___
24) Does your child cough, wheeze, or have trouble breathing during or after activity?…………………. yes___ no ___
25) Does your child use any special protective, or corrective equipment (for example: back brace, orthotics, hearing aid)?……….. yes___ no ___
26) Has your child had any problems with his/her eyes or vision, or wear glasses?………………….... yes___ no ___
27) Has your child had any problems with his/her hearing, or have tubes in his/her ears?………………. yes___ no ___
28) Has your child had dental cavities or problems with his/her teeth or gums?…………………….. yes___ no ___
29) Has your child had any broken bones, or problems with pain or swelling in muscles, bones or joints?…………… yes___ no ___
30) Do you feel your child is over or under weight?……………………………………….... yes___ no ___
31) Do you feel your child is stressed out, or emotionally upset?………………………………... yes___ no ___
32) (*for girls only*) Has your daughter started her menstrual period?…………………………….. yes___ no ___
If yes: When was her first menstrual period? Age ____ When was her most recent period? _______
How many days does the period last? _______ Do you or she have concerns about her menstrual periods?………………yes___ no ___
33) Is there family history of any of the following medical problems? Circle any that apply……………...yes___ no ___
   Diabetes, Heart disease, Sudden cardiac death, Seizure disorder, Emotional disorders, Developmental disorders, High blood pressure, Allergies,
   Other ____
Do you have any other concerns about your child's health? ______________________________________
Does your child have special dietary requirements or restrictions? ___ Explain: ______________________
____

Explain all "yes" answers:

____
____
____
____
____

Parent/Guardian's signature ______________________________________ **Date**____________

PLEASE COMPLETE OTHER SIDE

CONFIDENTIAL

ITHACA CITY SCHOOL DISTRICT

DEVELOPMENTAL HISTORY

DATE______________________

CHILD'S NAME_______________________________BIRTHDATE________________________
PARENT/GUARDIAN NAME____
PARENT/GUARDIAN NAME____

PRENATAL HISTORY

Prenatal care received Yes___ No____
Health during pregnancy Good_________ Concerns: (examples: diabetes, asthma, high blood pressure, toxemia) ____
Was there use of tobacco, drugs/alcohol or any medications during this pregnancy?
____
Birth:
Full term _________ Premature (number of weeks)_______________________________________
Vaginal __________ C-Section (reason)____

INFANT

Birth Weight________________
Any special care required after birth? Please explain_______________________________________
____

DEVELOPMENTAL

At what age did your child Sit__________Crawl__________Walk__________________________
Speech: Age at first words________________________
Has your child ever had speech services recommended?_______________________________________
Has your child received any speech therapy?____
____
How would you rate your child's coordination?
Small motor: below average average above average
Large motor: below average average above average
Is your child toilet trained? Day?__________Night?________During naptime?_______
Is your child left or right handed? Left________Right________
Do you have any concerns about your child's development? Please explain_____________________
____

PREVIOUS SCHOOLING

Did your child attend day care or nursery school? Yes No
If yes, where?____________________________________How long__________________________
Do you have any concerns about your child attending school?_________________________________