GLEN ROCK PUBLIC SCHOOLS

HEALTH HISTORY - ELEMENTARY SCHOOLS

Health History *(to be completed by Parent/Guardian)*

Name: _____ Grade: _____ Gender: _____

Date of Birth: _____ Place of Birth: _____ Birth Weight: _____

Normal Vaginal Delivery: _____ Forceps: _____ Caesarian Section Delivery: _____

Problems, if any, during pregnancy, labor, infancy: _____

_____

Developmental Milestones - *at what age did this child attain the following* **:**

Walk: _____ Talk: _____ Toilet Trained: _____ Feed Self: _____

COMMUNICABLE DISEASE HISTORY *(indicate month and year)*

Chickenpox: _____ Measles: _____ Mumps: _____ Rubella: _____

Pertussis: _____ Strep Throat: _____ Scarlet Fever: _____

DISEASE HISTORY *(indicate month and year of onset/episode)*

Bronchitis: _____ Ear Infection: _____ High Fever: _____ Of: _____

Allergies *(type)* : _____ Asthma: _____ Medications for Either: _____

Allergy to Bee Venom: _____ Nuts: _____ Describe: _____

IMMEDIATE ACTION TO BE TAKEN: _____

Heart Condition *(describe)* : _____

Convulsions: _____ Kidney Problems: _____ Spina Bifida: _____

Urinary Tract Infection: _____ Diabetes: _____

INJURIES, HOSPITALIZATIONS, SURGERY *(indicate month and year)*

Concussion: _____ Fractures: _____ Stiches: _____

Surgery: _____ Hospitalization: _____ Other: _____

Medical and Developmental Concerns:

Hearing: _____ Speech: _____

Does this child wear glasses?: _____ Condition: _____ Use of other appliance: _____

Explain any of the above: _____

Does this child require medication? *(explain):* _____

I certify that the information provided herein is accurate to the best of my knowledge as of the date of my signature. I hereby authorize the release of pertinent medical information to be shared among appropriate professional staff involved in the care of my child.

Signature: _____ Date: _____

Parent/Guardian