WEST IRONDEQUOIT CENTRAL SCHOOL DISTRICT

Health and Development History

I. Student Information

Name_____ Sex M F Date of Birth_____

Address_____

Doctor_____ Office Number_____

Dentist_____ Office Number_____

Father's Name_____ Mother's Name_____

Child lives with: Both Parents:_____ Mother:_____ Father:_____ Other:_____

Language(s) spoken at home:_____

II. Pregnancy and Birth History: (Please complete to the best of your knowledge).

1. Did mother have any illness or complication during pregnancy or delivery? If YES, please explain:

   _____

   _____

2. Was the child's delivery date: On due date_____ Preterm____ Post Dates_____

WICSD HEALTH AND DEVELOPMENT HISTORY

Student Name _____

III.	**Development History (to be filled out by K-6 only)**	**NO**	**YES**
	Is your child shy or timid?	____	____
	Does your child play well with others	____	____
	Does your child follow directions?	____	____
	Have you noticed…if yes, explain:		
	Nail biting_____	____	____
	Thumb sucking_____	____	____
	Temper tantrums_____	____	____
	Bed wetting_____	____	____
	Did your child go to pre-school?	____	____
	If yes, where?_____		
	How many days per week? _____		

WICSD HEALTH AND DEVELOPMENT HISTORY

Student Name _____

IV. Health History. If you answer YES to any of the concerns below, please explain:

	NO	YES
Frequent ear aches _____	____	____
Hearing concerns_____	____	____
Ear tubes_____	____	____
Hearing aids_____	____	____
Vision concerns_____	____	____
Wears glasses_____	____	____
Wears contacts_____	____	____
Frequent sore throats _____	____	____
Bowel movement concerns_____	____	____
Urination concerns_____	____	____
Sleep difficulties_____	____	____
History of seizures_____	____	____
Dental concerns_____	____	____
History of joint or bone injuries_____	____	____
Allergies_____	____	____
Medication for allergies_____	____	____
Asthma_____	____	____
Medication/Inhaler for asthma_____	____	____
Dietary concerns (PLEASE NOTE ANY RESTRICTIONS AND INFORM TEACHERS ACCORDINGLY)	____	____

_____

_____

WICSD HEALTH AND DEVELOPMENT HISTORY

Student Name _____

V. Medical History

Has your child ever had or does he/she now have:	NO	YES
Hepatitis	____	____
Sickle Cell Anemia	____	____
Measles	____	____
Rubella	____	____
Chicken pox	____	____
Spinal Curvature	____	____
Emotional Problems	____	____
Hernia	____	____
Hemophilia	____	____
Rheumatic Fever	____	____
Scarlet Fever	____	____
Whooping Cough	____	____
Mononucleosis	____	____
Heart Disease	____	____
Kidney Disease	____	____
Joint Disease	____	____
Fainting Spells	____	____
Migraine Headaches	____	____
Head Injury	____	____
Diabetes	____	____
Pneumonia	____	____

If yes, please explain and add any additional information that is pertinent:

_____

_____

Parent Signature: _____ Date:_____