

# South Brunswick School District

## PUPIL HEALTH HISTORY

Grades Pre – K – 5

Pupil's Name \_\_\_\_\_ Date of Birth \_\_\_\_\_ Sex \_\_\_\_\_ Grade/Teacher \_\_\_\_\_  
Address \_\_\_\_\_ Telephone: Home \_\_\_\_\_  
Parent/Guardian's Name(s) \_\_\_\_\_ Work \_\_\_\_\_  
Health Care Provider \_\_\_\_\_ Telephone Number \_\_\_\_\_

### Health History and Development:

- Length of pregnancy \_\_\_\_\_ months Complications of pregnancy? \_\_\_\_\_  
Delivery (circle one) Normal Caesarian Premature  
Birth Weight \_\_\_\_\_ lbs. \_\_\_\_\_ oz.  
Problems at birth/delay sending newborn home? If yes, please explain \_\_\_\_\_
- Birth sequence of above child 1<sup>st</sup> \_\_\_\_\_ 2<sup>nd</sup> \_\_\_\_\_ 3<sup>rd</sup> \_\_\_\_\_ 4<sup>th</sup> \_\_\_\_\_ other \_\_\_\_\_
- Any problems during first year? \_\_\_\_\_
- What age did your child walk? \_\_\_\_\_ talk? \_\_\_\_\_ toilet train? \_\_\_\_\_
- Does your child have any of the following problems? Vision \_\_\_\_\_ Hearing \_\_\_\_\_ Speech \_\_\_\_\_
- Does your child have asthma or a breathing problem? Yes \_\_\_\_\_ No \_\_\_\_\_ If yes, explain \_\_\_\_\_  
\_\_\_\_\_
- Is your child allergic to food, plants, dust, dogs, cats, bees, other? Yes \_\_\_\_\_ No \_\_\_\_\_ If yes, explain \_\_\_\_\_  
\_\_\_\_\_
- Does your child take medications? Yes \_\_\_ No \_\_\_ If yes, explain \_\_\_\_\_  
\_\_\_\_\_
- Has your child ever had an operation or medical procedure requiring outpatient services or hospitalization?  
Yes \_\_\_/Year \_\_\_\_\_ No \_\_\_\_\_ If yes, please explain \_\_\_\_\_  
\_\_\_\_\_

### Medical History (Indicate age)

Measles _____	German Measles _____	Mumps _____	Frequent nosebleeds _____
Scarlet Fever _____	Whooping Cough _____	Epilepsy _____	Frequent sore throats _____
Pneumonia _____	Ear infections _____	Diabetes _____	Frequent headaches _____
Convulsions _____	Tubes in ears _____	Fractures _____	Liver Disease _____
Polio _____	Hearing aid _____	Tonsillitis _____	Tuberculosis _____
Heart Disease _____	Sickle Cell _____	Anemia _____	Lyme Disease _____
			Chicken Pox _____

### Habits & Personality:

How does he/she play with friends? \_\_\_\_\_

Sleeps from \_\_\_\_\_ to \_\_\_\_\_ Nightmares? \_\_\_\_\_ Appetite? \_\_\_\_\_

Please describe your child in terms of his/her temperament and attitudes. Also, in what way is your child like other children or different from them? What words would best describe your child? \_\_\_\_\_  
\_\_\_\_\_

Is there anything about your child's health not mentioned above that we should know? \_\_\_\_\_  
\_\_\_\_\_

Any restrictions or limitations to physical activity? \_\_\_\_\_

Date \_\_\_\_\_ Signature of Parent/Guardian \_\_\_\_\_