COUNCIL ROCK SCHOOL DISTRICT

FAMILY HEALTH HISTORY

Child's Name ________________________________ M☐ F☐ Birth Date ________________

Address ____

Telephone ______________________ Birth Place ______________________________

Father's Name __________________________ Mother's Name __________________________

Family Doctor ________________________________ Telephone ______________________

Name of Pre-School Program ____

CHILD'S HISTORY

Does your child have:	**Yes**	**No**
Allergies	___	___
If yes, explain ______________________		
Asthma	___	___
Ear Infections	___	___
Convulsions	___	___
Frequent Colds	___	___
Frequent Sore Throats	___	___
Speech Difficulties	___	___
Vision Problems	___	___
Other Concerns	___	___
Is your child on any medications	___	___
List medications ______________________		

Has your child had:	**Yes**	**Date (yr)**
Chickenpox	___	__________
Head Injury/Concussion	___	__________
Febrile Convulsions	___	__________
Hepatitis	___	__________
Measles, German	___	__________
Measles, Regular	___	__________
Mononucleosis	___	__________
Mumps	___	__________
Polio	___	__________
Rheumatic Fever	___	__________
Scarlet Fever	___	__________
Whooping Cough	___	__________
Other ______________________________		

If your child has a history of **Head Injury/Concussion** – Please explain:______________________________

Did mother have measles or other serious illness during pregnancy? ____________________

Was oxygen administered to your child at birth? ____________________

Any serious illnesses or surgery? __________ If yes, what? ________________________________

Is your child under medical treatment? __________ If yes, explain ____________________________

State any other information which would aid the school in a better understanding of your child.

Family History

Is there a history of:	**Yes**	**Relationship**
Allergies	___	_________
Asthma	___	_________
Color Deficiency (Blindness)	___	_________
Convulsive Disorders	___	_________
Diabetes	___	_________
Hearing Disorders	___	_________
Reading Disorders	___	_________
Tuberculosis	___	_________
Visual Disorder	___	_________
Other	___	_________

Child's Developmental History

Birth Weight ______________________

Age Walked ______________________

Age Talked ______________________

Age Toilet Trained ________________

Age Stopped Bed-Wetting ____________

______________________ ______________________________________

Date *Signature of Parent/Guardian*