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	___	________
Febrile Convulsions	___	________
Hepatitis	___	________
Measles, German	___	________
Measles, Regular	___	________
Mononucleosis	___	________
Mumps	___	________
Polio	___	________
Rheumatic Fever	___	________
Scarlet Fever	___	________
Whooping Cough	___	________
Other ______________________________		

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