CHILD’S HEALTH HISTORY CHECKLIST

_______________________________   ________________  ____________________
Child’s name                                             Birth Date

Parent or Guardian Name

Please note any allergies or disabilities:

The answer to these questions will help us to know if your child has any medical problems. We need this information in case he/she should become ill and we would be unable to reach you right away. Please circle the right answer. We will go over the checklist with you when you have finished.

Pregnancy and Birth

YES  NO   1) Were there any problems with pregnancy or your child’s birth?
YES  NO   2) Was his/her birth weight under 5 ½ pounds?
YES  NO   3) Did the baby have any problems in the hospital?

Medical Problems

YES  NO   1) Has your child ever been in the hospital overnight?
YES  NO   2) Is your child taking any medicine?
YES  NO   3) Any allergies or reactions to medicine, DTP or other shots, or insects?
YES  NO   4) Has your child had asthma or wheezing?
YES  NO   5) Does your child have speech or hearing problems?
YES  NO   6) Has your child had more than two ear infections in a year?
YES  NO   7) Has your child had tonsillitis?
YES  NO   8) Does your child have trouble with his/her eyes or seeing?
YES  NO   9) Has your child had a bladder or kidney infection?
YES  NO  10) Does he/she have burning when urinating?
YES  NO  11) Does he/she have seizures, fits, or shaking spells?
YES  NO  12) have you ever been told your child has a heart murmur?
YES  NO  13) Is your child able to play as hard as other children?
YES  NO  14) Has your child ever been with anyone having TB?
YES  NO  15) Has your child ever had worms?
YES  NO  16) Does your child scratch his/her genital area?
   Is his/her bottom or genitals red or sore?
YES  NO  17) Is your child a hemophiliac (free bleeder)?
YES  NO  18) Is your child on a heart monitor?
YES  NO  19) Does your child have tubes in his/her ears?

General Development

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YES  NO  1) is your child in a special education class in school?
YES  NO  2) Does your child get along with other children?
YES  NO  3) Is he/she usually happy?
YES  NO  4) Does your child have any special problems not indicated above?
YES  NO  5) When did your child last see a doctor? ________________

Good Shepherd School requires that a child be free of fever for 24 hours before returning to school. Also a child must have had an antibiotic in his/her system 24 hours before returning to school.

I have read the above information about the school policy pertaining to sick children
Please sign ____________________________________

EMERGENCY INFORMATION:
Name of person authorized to act for parent in an emergency ____________________________
Address ___________________________ Phone # ___________________ Cell# ____________________
Where employed ____________________ Work Address ________________________________
Work Telephone ____________________ Work Address ________________________________

Physician Information:
Name ______________________________________
Address ____________________________
Office Number _______________________