INITIAL HEALTH ASSESSMENT

IDENTIFYING INFORMATION:

LEGAL NAME OF CHILD: ______

BIRTHDATE: ______ AGE: ______ SEX: ______ GRADE: ______

ADDRESS: ______

This form is completed by: ______ Relationship to Child: ______

Parent/Guardian PHONE: Home ______ Work ______ Cell ______

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Parent/Guardian PHONE: Home ______ Work ______ Cell ______

Message Number: ______ Best time to call: ______

Child lives with: Both Parents ☐ Mother ☐ Father ☐ Other (explain) ______

Language spoken in home: English: ☐ Other (list) ______

My child has the following health care coverage: Medicaid: ☐ CHP+ ☐ Private: ☐ None: ☐

PREGNANCY AND BIRTH:

Month into pregnancy that medical care began: ______ Length of pregnancy: ______

Were there any medications taken while pregnant?

Explain: ______

Length of labor: ______ Birth Weight: ______

Did baby come home with mother? Yes ☐ No ☐

Explain: ______

Did the baby need oxygen after birth: Yes ☐ No ☐

Explain: ______

Did baby turn yellow enough to be treated? Yes ☐ No ☐

Explain: ______

DEVELOPMENTAL HISTORY:

Did your child crawl by 9 months? Yes ☐ No ☐

Did your child walk by 18 months? Yes ☐ No ☐

Did your child say words by 15 months? Yes ☐ No ☐

Was your child toilet trained by 3½ years? Yes ☐ No ☐

Were there problems with balance coordination? Yes ☐ No ☐

Were there problems with fine motor skills? (buttons, handwriting, picking something up) Yes ☐ No ☐

Do you have other concerns about your child's development? Yes ☐ No ☐

Explain: ______

ILLNESSES, HOSPITIALIZATIONS, SURGERIES, AND/OR ACCIDENTS:

Major Illnesses: ______

Hospitalization/Surgeries: ______

Accidents/Injuries: ______

Child's Doctor: ______ Date of Last Visit: ______ Reason: ______

BODY SYSTEMS HISTORY:

TEETH:

Are there any dental concerns? Yes ☐ No ☐

Explain: ______

Date of Last Dental Exam: ______ Dentist: ______

EARS:

Does your child have any known hearing problems? Yes ☐ No ☐

Explain: ______

Do you have any concerns about your child's hearing? Yes ☐ No ☐

Explain: ______

Ear Infections? No ☐ Yes ☐ Age when started? ______ How many per year? ______

Within last year? No ☐ Yes ☐ Were PE tubes placed? No ☐ Yes ☐ Number of sets? ______

EYES:

Does your child have any problems seeing? Yes ☐ No ☐

Explain: ______

Does your child wear glasses/contacts? Yes ☐ No ☐

When? ______

Date of last eye exam? ______ Doctor's Name: ______

CARDIAC:

Does your child have any heart problems? Yes ☐ No ☐

Explain: ______

Does your child fatigue easily, or have poor endurance? Yes ☐ No ☐

Explain: ______

RESPIRATORY:

Does your child have any breathing problems? Yes ☐ No ☐

Explain: ______

Is he/she prone to upper respiratory infections? Yes ☐ No ☐

Explain: ______

Does your child have asthma? Yes ☐ No ☐

Triggers: ______

Uses inhaler, nebulizer, or medication? Yes ☐ No ☐

GASTROINTESTINAL AND URINARY:

Does your child have any problems going to the bathroom? Yes ☐ No ☐

Explain: ______

Bedwetting: Yes ☐ No ☐

Constipation: Yes ☐ No ☐

Difficult to train: Yes ☐ No ☐

Does your child have dietary/food needs or concerns? Yes ☐ No ☐

Explain: ______

Does your child have frequent stomach aches? Yes ☐ No ☐

Explain: ______

SKELETAL AND MUSCULAR:

Has your child ever had a broken bone? Yes ☐ No ☐

When and which one? ______

Does your child have any physical disabilities? Yes ☐ No ☐

Explain: ______

Are there any restrictions for activity? Yes ☐ No ☐

Explain: ______

NEUROLOGICAL:

Has your child ever had seizures? Yes ☐ No ☐ Date of last seizure: ______

Does your child have frequent headaches? Yes ☐ No ☐ Explain: ______

Has your child ever had a head injury or concussion? Yes ☐ No ☐ If unconscious, how long? ______

After injury: Dizziness? ☐ Memory problems? ☐ Headaches? ☐ Fatigue? ☐

Was a physician seen? Yes ☐ No ☐ Who? ______

Hospitalized? Yes ☐ No ☐ Where? ______

Does your child have sleeping/bedtime concerns? Yes ☐ No ☐

Explain: ______

Does your child have a limited attention span? Yes ☐ No ☐

Do you think your student is distractible? Yes ☐ No ☐

Is your student impulsive? Yes ☐ No ☐

ALLERGIES: (Identify and explain)

Medications allergies? Yes ☐ No ☐ What/Reactions: ______

Food Allergies? Yes ☐ No ☐ What/Reactions: ______

Insect/wasp/bee sting allergy? Yes ☐ No ☐ What/Reactions: ______

Environmental Allergies? Yes ☐ No ☐ What/Reactions: ______

Seeing an Allergist? Yes ☐ No ☐ Who/When?: ______

MEDICATIONS:

Is your child currently taking medications (prescription and/or over-the-counter)? Yes ☐ No ☐

List Name, Dose, and Time: ______

This form can be used to complete my child's record in the student information system. Yes ☐ No ☐

______ ______

Signature of person completing this form Date

Interpreter (if applicable): ______