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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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): _____