HEALTH & DEVELOPMENTAL HISTORY REPORT
Buckeye Union School District

Student Name_____ Age _____Birth Date _____ Circle: M F
School_____Grade_____Teacher_____

Please use the back of this form to provide details if necessary.

FAMILY HISTORY:

- Living with: Mother___ Father_____ Step-parent____ Other (Who?) _____
- Who lives at your home? Names and ages:_____

_____

PRENATAL HISTORY:

- Was this baby full term?_____ Premature?_____ How many weeks/months? _____
- Complications (bleeding, illness, injury) _____
- Medication(s) taken during pregnancy _____
- Caffeine _____ Alcohol _____ Smoking _____ Other _____

DELIVERY & NEONATAL:

- Labor (any problems, anesthesia) _____
- Birth weight _____Birth length _____ Type of birth: Vaginal _____ C Section _____
- Birth Complications: The baby was blue ___ Needed Oxygen ___ Had cord around neck ___Had jaundice ____
- Did the baby breathe right away? _____ Did the baby go home with mother? _____

DEVELOPMENT:

- Was your child's development: (A) average (L) Late or (E) Early for: gross motor (walking, running) ____, fine motor (coloring, using a spoon) ___ , speech ___ , self help (dressing, brushing teeth) _____, toilet training? _____

SOCIAL BEHAVIORAL HISTORY:

- Describe your child's strengths _____
- My child is: Happy _____Unhappy _____ Easy going _____ Difficult to live with _____ Explain:_____
- What are your child's activities outside of school? _____

_____

- Does your child have friends at school? _____ At home? _____
- What is his/her relationship with brothers/sisters? _____

INTERVENTIONS

- Did your child receive special programs (Circle which)? Infant, ALTA, CCS, County, Speech, Occupational Therapy, Physical Therapy, Nursing, Other_____

MEDICAL HISTORY:

- Did your child have any illnesses, hospitalizations, or surgeries?_____

  _____
- Does your child have any physical defects or disabilities?_____
- Does/did your child have any of the following conditions? (Please circle all that apply)
  Asthma Allergies Ear infection Seizures High fever ADD/ADHD
  Head injury or serious accident Bowel/Bladder problems Other: _____
  Please provide details including age and treatments for any conditions circled above:_____

  _____
- Is your child on medication now?_____ Name of medication_____
- Takes how much? _____How often? _____Started when?_____

CURRENT HEALTH STATUS:

- How would you describe your child's overall health?_____
- Date of last physical exam_____ Doctor_____
- Date of last eye exam_____ Doctor_____
- Date of last dental exam_____ Doctor_____
- Any concerns not already mentioned?_____

Parent/Guardian completing form (Print): _____ Date_____