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**	**Has your child had:**	**Yes**	**Date (yr)**
Allergies	___	___	Chickenpox	___	_____
If yes, explain _____			Head Injury/Concussion	___	_____
Asthma	___	___	Febrile Convulsions	___	_____
Ear Infections	___	___	Hepatitis	___	_____
Convulsions	___	___	Measles, German	___	_____
Frequent Colds	___	___	Measles, Regular	___	_____
Frequent Sore Throats	___	___	Mononucleosis	___	_____
Speech Difficulties	___	___	Mumps	___	_____
Vision Problems	___	___	Polio	___	_____
Other Concerns	___	___	Rheumatic Fever	___	_____
Is your child on any medications	___	___	Scarlet Fever	___	_____
List medications _____			Whopping Cough	___	_____
_____			Other _____		

If Your Child has a history of **Head Injury/Concussion** –Please explain:_____
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