

CAMPBELL CITY SCHOOLS HEALTH HISTORY

Your child's success in school rests to a very great extent on his or her well being. It is extremely important for the school to have some information about every child's health status. Health clearance is also required periodically for participation in certain school activities. In order to have correct health information of value to the school, we would appreciate your responses to the following.

CHILD'S NAME _____ BIRTH DATE _____

BIRTH AND EARLY DEVELOPMENTAL HISTORY

- A) Were there any prenatal complications? _____ Please describe _____
- B) Birth weight _____ Delivery (Please check one) Normal _____ Caesarian _____
- C) Condition of child after birth: (Please check if applicable) Jaundice _____ Anoxia _____
Transfusion _____ Other _____
- D) Physical Growth: (check one) Normal _____ Slow _____ Fast _____
- E) Age child: First sat alone _____ First crawled _____ Walked _____ Talked _____

FAMILY HISTORY

Has any blood relative of this child ever had any of the following? If yes, please list relationship to child at right:

- | RELATIONSHIP | RELATIONSHIP |
|------------------------------|-------------------------|
| A) Tuberculosis _____ | G) Cancer _____ |
| B) Asthma _____ | H) Heart Problems _____ |
| C) Epilepsy _____ | I) Allergies _____ |
| D) Diabetes _____ | J) Mental Problem _____ |
| E) High Blood Pressure _____ | K) Sickle Cell _____ |
| F) Kidney Problems _____ | L) Strep Throat _____ |

CHILD'S MEDICAL HISTORY

- a) Is child under a physician's care for chronic illness at present? _____
- b) If yes, describe _____
- c) Illnesses:

	YEAR		YEAR		YEAR
Bronchitis	_____	Impetigo	_____	Seizures	_____
Chicken Pox	_____	Pneumonia	_____	Sinusitis	_____
Croup	_____	Rheumatic Fever	_____	Stomach Problem	_____
Ear Infection	_____	Ringworm	_____	Strep Throat	_____
High Fever	_____	Scarlet Fever	_____	Tonsillitis	_____

- d) Allergies (please list):

Drugs _____ Plants _____

Foods _____ Insect bites _____