

Health Assessment and Medical Review

Initial Health Assessment

Student's Name: _____ Birth Date: _____

Parent/Guardian: _____ Phone: _____

Address: _____ School/Grade: _____

Completed by: _____ Relation to Student: _____

Prenatal and Birth History

Mother's age at time of birth _____ Any instruments used? _____
Length of pregnancy _____ Single or Multiple birth _____
Number of pregnancies _____ If Multiple, which number? _____
Which pregnancy (1st, 2nd, etc.) _____ Drugs given during labor _____
When Doctors care began _____ Baby's birth weight _____
Vaginal or C-section Delivery _____ Mother's length of hospital stay _____
Length of Labor _____ Baby's length of hospital stay _____
Was labor induced? _____

Please circle:

Was this pregnancy considered "high risk"? YES NO

Explain: _____

Did you smoke, drink, or take drugs during your pregnancy? YES NO

What Substance? _____ How much daily or weekly? _____

Were medications taken during pregnancy? YES NO

What medication? _____ When Started? _____ When Stopped? _____

Please Circle any of the following that you experienced during pregnancy

Vomiting with dehydration	High Blood Pressure	Hospitalizations
Accidents	RH negative	Poor Health during Pregnancy
Fever	Virus Infections	Anemia
Skin Rashes	X-rays-Ultrasound	Post-partum Depression

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What was the baby's condition at birth?

Difficulty Breathing? Yes No

Jaundice? Yes No

Difficulty eating? Yes No

Any other medical concern at birth: _____

If adopted, at what age was he/she adopted: _____

Is the child aware of the adoption? Yes No

Developmental History and Behaviors

Developmental: Please check the appropriate column indicating the approximate age of development

	Early	Normal	Late		Early	Normal	Late
Sat up	_____	_____	_____	First Words	_____	_____	_____
Crawled	_____	_____	_____	Talked Sentences	_____	_____	_____
Walked	_____	_____	_____	Toilet Trained	_____	_____	_____
Used a Spoon	_____	_____	_____	Age when dry at night	_____	_____	_____
Used a Cup	_____	_____	_____	Tied Shoes	_____	_____	_____
Stopped pacifier	_____	_____	_____	Used Scissors	_____	_____	_____

Please indicate your child's:

General disposition/temperament: easy-going difficult sometimes both
General Activity level: High Low Average
Response when tired/fatigued: Becomes irritated Falls Asleep Becomes Excited
Response to stress/frustration: Becomes Angry Withdraws Bites Nails Sucks Thumb

Describe your child's reaction to discipline or changes in their routine:

Medical History

Date of last physical exam: _____

Date of last Eye exam: _____

Does your child wear glasses? _____ If yes, when were they prescribed? _____

Are your child's immunizations up-to-date? Yes No

Child's Height _____ Weight _____

Child's overall physical condition: Excellent _____ Good _____ Fair _____

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Does your child take any medications? If yes, please list below: Name of the medication, dose, time taken and length of treatment and please include any over the counter medications.

Does your child have a diagnosed health/emotional condition? ie., asthma, ADHD, diabetes, etc. If yes, please list chronic condition and date diagnosed below:

Does your child have any known allergies to any food or medication? If yes, is this provided from the physician? Please list all allergies below:

Has your child ever been hospitalized overnight? If yes, please explain the age, reason and duration of the stay below:

Has the child ever had any accidents including head injury, stitches, or broken bones? If yes, please provide age, detail and duration of the treatment below:

Does your child have any current medically related complaints? If yes, please describe below:

Other Health concerns or parent concerns regarding your child:

Has there been any serious illness, death divorce or other traumatic experience which you feel has had an effect on your child? If yes, please describe below:

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Family/Child History

Please list the family members in the space provided if applicable.

Diabetes _____ Heart Disease _____
Epilepsy _____ Hypertension _____
Emotional Illness _____ Addictions _____
Cancer _____

Please check all that apply to your child and list approximate age or comment if needed

Diabetes Type/Dose of Insulin _____ Asthma/Use of Inhaler _____
Ear Tubes/Frequent Ear Infections _____ Convulsions/Seizures _____
_____ Indigestion _____ Urinary Problems _____ Constipation/Diarrhea
_____ Heart Problems _____ Vomiting _____ Allergies
_____ High Fevers _____ Headaches _____ Weakness/Fatigue

General Information

What is the main language spoken at home? _____

How many hours of sleep does your child get each night? _____

Is your child a restless sleeper? _____

Does your child have a good appetite? _____

Does your child eat from all of the food groups? If No, please indicate: _____

Thank you for taking the time to complete this medical review interview sheet. Please return it to your child's school health office.

Parent Signature: _____ Date Completed: _____