AFTERSCHOOL CHILD'S HEALTH HISTORY FORM

GRADE K THRU 5

_____ _____ _____

Child's Name | Date of Birth | Parent's/Guardian's Name

The answers to these questions will help us to know if your child has any medical problems. We need this information in case he/she should become ill and we would be unable to reach your right away. Please circle the appropriate answer. We will go over the checklist with you when you have finished.

PREGNANCY AND BIRTH

YES	NO	
☐	☐	1. Were there any problems with pregnancy or child birth?
☐	☐	2. Was his/her birth weight under 5½ pounds?
☐	☐	3. Did he/she have any problems in the hospital?

MEDICAL PROBLEMS

YES	NO	
☐	☐	4. Has your child ever been hospitalized?
☐	☐	5. Is your child taking any medications?
☐	☐	6. Any allergies or reactions to medicine, DTP or other shots or insects?
☐	☐	7. Has your child had asthma or wheezing?
☐	☐	8. Does your child have speech or hearing problems?
☐	☐	9. Has your child had more than two ear infections in a year?
☐	☐	10. Has your child had tonsillitis?
☐	☐	11. Does your child have trouble with his/her eyes or seeing?
☐	☐	12. Has your child had a bladder or kidney infection?
☐	☐	13. Does your child have a burning sensation when urinating?
☐	☐	14. Does your child have seizures, fits, or shaking spells?
☐	☐	15. Have your ever been told your child has a heart murmur?
☐	☐	16. Is your child able to play as hard as other children?
☐	☐	17. Has your child ever had a bumpy, swollen reaction to the TB skin test?
☐	☐	18. Has your child ever been with anyone having TB?
☐	☐	19. Has your child ever had worms?
☐	☐	20. Does your child scratch his/her genital area? Or Is his/her bottom or genitals red or sore?
☐	☐	21. Is your child a hemophiliac (free bleeder)?
☐	☐	22. Is your child on a heart monitor?
☐	☐	23. Does your child have tubes in his/her ears

OLDER GIRLS

YES	NO	
		24. How old was your daughter when she had her first period? _____
☐	☐	25. Does she have any problems with her period?

GENERAL DEVELOPMENT

YES	NO	
☐	☐	24. Is your child in a special education class in school?
☐	☐	25. Does your child get along with other children?
☐	☐	26. Is he/she usually happy?
☐	☐	27. Does your child have any special problems not indicated above? If YES, please explain:_____

_____

_____

28. When did your child last see a doctor? Month _____ 20_____

_____ _____

Signature of Parent or Legal Guardian | Date