WEST HARTFORD NON-PUBLIC SCHOOL
NURSING SERVICE

STUDENT DEVELOPMENTAL/HEALTH HISTORY

PLEASE PRINT:

NAME OF CHILD: _____ SEX: _____
(Last) (First) (Middle)

HOME ADDRESS: _____

PLACE OF BIRTH: _____ D.O.B. _____ HOME TEL. _____

PRIMARY LANGUAGE (language most often used at home) _____

IDENTIFYING INFORMATION

Father's Name: _____ Mother's Name: _____

Education: _____ Education: _____

Employment: _____ Employment: _____

MARITAL STATUS: Married _____ Divorced _____ Separated _____ Widowed _____ Single _____

CHILD LIVES WITH: _____ NO. OF CHILDREN IN FAMILY: _____

NAME	AGE	NAME	AGE
_____	____	_____	____
_____	____	_____	____
_____	____	_____	____

CHILD'S PHYSICIAN:

NAME: _____

ADDRESS: _____

TELEPHONE: _____

CHILD'S DENTIST:

NAME: _____

ADDRESS: _____

TELEPHONE: _____

BIRTH HISTORY

Did you have any illness during pregnancy with this child? _____ Yes _____ No

Was pregnancy full term? _____ Yes _____ No (If no, please explain) _____

_____

Was delivery normal? _____ Yes _____ No (if no, please explain) _____

_____

Did child receive oxygen at birth? _____ Yes _____ No Child's birth weight _____ lb. _____ oz.

Did child leave hospital with mother? _____ Yes _____ No (if no, what were the reasons: _____

_____

At what age did your child: Sit _____ Walk _____
(*Your best estimate*)
Complete toilet training _____ Use single words _____ Use three word phrases _____

At ages 2 and 3, which did he/she like to do? Listen to stories _____ play with puzzles _____
Watch TV _____ play with blocks _____ play with cars/dolls _____ listen to nursery rhymes _____

Does he/she like to draw? _____ cut _____ paste _____
Can he/she comfortably visit or play at a friend's home without you? _____ Yes _____ No
Does he/she cry when you leave? _____ Yes ____ No
At what age did he/she ride a tricycle? _____ Do you consider him/her coordinated? _____
Does he/she like to watch TV? _____ How long does he/she watch it? _____
What does he/she do while watching TV? _____
How does your child respond when he/she is read to? _____
At supper time, does he/she sit with the family? _____
Does he/she readily talk to family members, friends, etc.? _____
Will he/she begin the conversation? _____ Does he/she have difficulty choosing the words that express what he/she wants to say? _____
Does he/she get along with his brothers and sisters? _____
Have you noticed any change after the birth of other children?_____
Would you say he/she gets along better with father or mother? _____
Have there been any major changes in the family situation, such as moving, loss of someone close (death, separation, divorce), or serious illness, in the past year? _____
_____

Has your child ever participated in (please check):
_____ Headstart _____ Pre-School Program _____ Sunday School
_____ Organized groups of any kind _____ Nursery School

Can your child dress himself? _____ Partially
_____ Completely
_____ Not at all

Does your child do better in the afternoon if he/she has a nap? _____
If he/she still requires a nap is it usually (check one)
_____ Daily _____ Occasionally For how long? _____

HEALTH HISTORY

CHILD'S HEALTH HISTORY: In order to understand and care for your child at school, please check the appropriate column and explain as needed:

	Yes	No	Explain if yes
1. Was there any problem with your child after delivery or during the first year?			
2. Did your child double his/her birth weight by age 1?			
3. Has your child ever had a serious accident or illness?			
4. Has he/she ever been hospitalized?			
5. Has he/she ever had an operation?			
6. Has he/she ever had any broken bones or serious burns?			
7. Has he/she ever had a serious head injury or been knocked out?			
8. Has he/she ever had a convulsion?			
9. Has he/she ever taken medicines or poisons accidentally?			
10. Is your child allergic to anything? (i.e. food, medication, insect stings)			
11. Has he/she ever had an unusual reaction to an immunization?			
12. Does he/she eat anything which is not food? (i.e. starch, paint, dirt)			
13. Is your child taking any medication or does he/she take any on a regular basis?			
14. Does your child have trouble seeing, or does he/she squint or is cross-eyed?			
15. Has he/she ever had a professional vision test?			
16. Does he/she wear, or is supposed to wear glasses?			
17. Does your child have frequent ear infections?			

	Yes	No	Explain if yes
18. Does he/she favor one ear or seem to have trouble hearing?			
19. Has he/she ever had a professional hearing evaluation?			
20. Does your child wear a hearing aid?			
21. Does he/she have a persistently runny or stuffy nose?			
22. Does your child breathe through his/her mouth?			
23. Does he/she have frequent colds, coughs, or sore throats?			
24. Has anyone told you your child has asthma?			
25. Does your child tire easily?			
26. Does your child have frequent stomach pain, vomiting, diarrhea or constipation?			
27. Does your child wet or soil his/her pants?			
28. Does your child have any heart, bladder or kidney problems?			
29. Does your child limp or have any problems with his/her arms/legs?			
30. Does he/she complain of frequent headaches?			
31. Does he/she have trouble sleeping?			
32. Does he/she have problems with rashes?			
33. Does your child have any dental problems?			
34. Does your child have a chronic disorder such as diabetes, epilepsy or the like?			
35. Has your child ever received services from public health nurses, CT Children's Medical Center, The Bridge Family Center?			

We know any child can occasionally have other problems. Please check if your child has frequently had special difficulties with any of the following:

_____ feeding	_____ thumb sucking	_____ nightmares
_____ sleeping	_____ shyness	_____ angers quickly
_____ toilet training	_____ aggressiveness	_____ temper tantrums
_____ bed wetting	_____ crying easily	_____ rocking
_____ soiling	_____ head banging	

FAMILY HEALTH HISTORY (Please check and indicate who i.e. father, grandmother, etc.)

Is there anyone in the child's family who has had in the past or who presently has:

_____ fatal heart attack before age 60	_____ diabetes	_____ blood disease
	_____ allergies	_____ rheumatoid arthritis
_____ high blood pressure	_____ speech difficulties	_____ seizure disorder
_____ hearing difficulties	_____ learning disability	_____ other

Any other information which you would like to share:

I am aware that this information will be part of my child's permanent health record.

_____ _____

Parent/Guardian Signature Date

FOR USE AT PRE-KINDERGARTEN SCREENING BY THE SCHOOL NURSE

	RT	LT	BOTH	
Vision	_____	_____	_____	_____ Vision/Audio needs retesting
With glasses	_____	_____	_____	_____ Unable to rest
Hearing	_____	_____	_____	_____ Immature
				_____ URI
				_____ Other

Immunizations: _____ In order _____ Deficient, Needs	Physical: _____ Received _____ Not Received Appointment date on _____ with _____ _____ Signature of Nurse