RANDOLPH COUNTY SCHOOLS
BASIC HEALTH HISTORY

CHILD'S NAME _____ BIRTH DATE _____ SEX ___ M ___ F ___

DOCTOR _____ DENTIST _____

I. Check any of the following conditions your child has or had:

___ 1. Allergies: seasonal, food, medications, insect bites (specify)
___ 2. Asthma
___ 3. Autism
___ 4. Bleeding/Clotting Problems
___ 5. Cancer
___ 6. Chicken Pox
___ 7. Developmental Defects
___ 8. Diabetes
___ 9. Emotional/Psychological Problems
___ 10. Fractures
___ 11. Frequent sore throats (3 or more a year)
___ 12. Heart Disease
___ 13. Hyperactive/ADD/ADHD
___ 14. Jaundice
___ 15. Kidney Infections
___ 16. Learning Disabilities
___ 17. Leukemia
___ 18. 3-day Measles (Rubella)
___ 19. 9-day Measles (Rubeola)
___ 20. Mentally Impaired
___ 21. Mumps
___ 22. Orthopedic Defect
___ 23. Recurring Ear Infections
___ 24. Rheumatic Fever
___ 25. Scarlet Fever
___ 26. Seizures - Last Seizure: _____
___ 27. Sickle Cell
___ 28. Premature Birth
___ 29. Toileting Problems
___ 30. Tuberculosis
___ 31. Whooping Cough
___ 32. Other Chronic Conditions? List
_____

Please Explain:

_____

_____

_____

II. GENERAL HEALTH OF CHILD

1. Have you ever suspected that your child has a hearing problem? Yes ___ No ___

   If so, why? _____

   Treatment Necessary: _____

2. Has your child had any problems with his speech? Yes ___ No ___

   If so, what kind? _____

   Treatment Necessary: _____

3. Has anything led you to think that your child may have a vision problem? Yes ___ No ___

   If so, what? _____

   Treatment Necessary: _____

4. Has your child ever been hospitalized: Yes ___ No ___ How Long? _____

If so, why? _____

5. Does your child use prescribed medicines regularly? Yes ___ No ___

If so, what? _____

Treatment Necessary: _____

6. When was your child last seen by his doctor? _____

Name of doctor or clinic _____

7. When was your child last seen by his dentist? _____

Name of dentist or clinic _____

8. In general, how would you rate your child's health? (Circle one)

Poor Not so good Average Very Good Excellent

9. Is your child on a special diet? Yes ___ No ___

If so, what? _____

10. Is your child restricted in physical activity? Yes ___ No ___

If so, what? _____

11. Is there anything your child's teacher should know about your child's health?

Yes ___ No ___

If so, what? _____

12. Please list other family members (living under the same roof as the student)

Name	Age	Name	Age
1. _____		5. _____	
2. _____		6. _____	
3. _____		7. _____	
4. _____		8. _____	

13. Family History: Chronic health problems affecting other family members.

_____

14. Special Services presently being provided by Community Agencies.

_____

Parent's Signature _____ Date _____