DEVELOPMENTAL AND HEALTH HISTORY INFORMATION
WEST DELAWARE COUNTY COMMUNITY SCHOOL

STUDENT: _____
(Last) (First) (M)
GRADE: _____ **BIRTHDATE:** _____ **M F**

HOME ADDRESS: _____

FATHER'S NAME: _____ **BIRTHDATE:** _____

ADDRESS: (If different than students) _____

HOME PHONE: _____ **CELLPHONE:** _____

MOTHER'S NAME: _____**BIRTHDATE:**_____

ADDRESS: (If different than students) _____

HOME PHONE: _____ **CELLPHONE:** _____

STUDENT LIVES WITH: _____ NATURAL FATHER _____ NATURAL MOTHER _____ STEPFATHER
_____ STEPMOTHER _____ FOSTER PARENTS _____ GRANDPARENTS _____ AUNT/UNCLE
OTHER _____

NUMBER OF BROTHERS: _____ **AGES:** _____
NUMBER OF SISTERS: _____ **AGES:** _____

FAMILY PHYSICIAN: _____

FAMILY DENTIST: _____

Yes No IS YOUR CHILD COVERED BY HEALTH INSURANCE?

PLEASE FILL OUT INFORMATION ON PRENATAL /BIRTH CARE:

Received prenatal care Yes No Medications taken during pregnancy: _____
_____
Problems with pregnancy; bleeding, excessive swelling, weight loss, high blood pressure, infection, sickness, other Yes No
Problems with labor/delivery Yes No Baby arrived on time Yes No
Length of labor: _____ **Birth weight:** _____
Type of delivery: Normal Breech C-section Instruments
Please explain any of the above that is needed: _____

_____

PLEASE FILL OUT INFORMATION ON YOUR CHILD'S DEVELOPMENT:
List ages as closely as you can remember, when your child:

Sat alone_____ **Walked alone**_____ **Said first word** _____

Y N Child's speech is understandable to others?

Y N Child has been treated for foot, leg, hip or other bone development problems?
If so, what AGE _____ **FORM OF TREATMENT**_____

_____

OVER

Y N Is child toilet trained? Day Wetting? Y N Night Wetting? Y N

Y N Child has problem with bowel control? Explain: _____

_____

DO YOU THINK YOUR CHILD IS DEVELOPING AS MOST CHILDREN HIS/HER AGE?

Physically? Y N Mentally? Y N Emotionally? Y N

Please comment: _____

_____

PLEASE FILL OUT INFORMATION ON YOUR CHILD'S HEALTH HISTORY:

Y N Any Hospitalizations? Age and reason: _____

_____

Y N Serious accidents/injuries? Age and reason: _____

_____

Childhood diseases? (Examples like chicken pox, mumps, scarlet fever, RSV)_____

_____

Y N Appetite problems? _____

Y N Frequent ear infections?
Surgery/tubes: _____ **Date:** _____

Y N Glasses? Date: _____

Y N Convulsions (seizures)? Age of onset: _____

Describe seizure and date of last seizure: _____

_____

Y N Lead screening? This will be completed on your child's physical form but if a physical is not completed then the information MUST be filled in here. Date/Results: _____ **Treatment:** _____

Y N Child has allergies? Please circle type of allergy: Asthma Hayfever Insect bites/Stings Dust/Mold

Y N Food allergies? Describe: _____

Y N Medication allergies? Describe: _____

ARE EMERGENCY PROCEDURES REQUIRED FOR ANY OF THE ABOVE CONDITIONS?
(Such as an Epipen for severe allergies to bees/insects)

_____

_____

_____

_____