THOMPSON R2-J SCHOOL DISTRICT
HEALTH SERVICES

HEALTH, DEVELOPMENTAL AND SOCIAL ASSESSMENT INFORMATION

TODAY'S DATE_____________
NAME____ SEX: M/F DATE OF BIRTH_____________
ADDRESS____ PHONE___________________
PRESENT SCHOOL____________________________________ GRADE___________________
PERSON(S) FILLING OUT FORM____
RELATIONSHIP TO CHILD____
FATHER'S NAME___________________________ MOTHER'S NAME___________________________
OCCUPATION_____________________________ OCCUPATION_______________________________
PARENT RELATIONSHIP TO CHILD: NATURAL ADOPTED
LIVING WITH BOTH PARENTS MOTHER ONLY FATHER ONLY GUARDIAN
SIBLINGS NAME AND DATE OF BIRTH LIVING AT HOME?
(brothers/ _____________________________________ ______________________________
sisters) _____________________________________ ______________________________
_____________________________________ ______________________________
_____________________________________ ______________________________
WHO ELSE LIVES WITH CHILD?____
MAJOR LANGUAGE IN HOME?____
CHILD'S PHYSICIAN_______________________________ DATE OF LAST PHYSICAL_____________
HAS YOUR CHILD BEEN SCREENED OR EVALUATED BEFORE? YES_____ NO_____
IF YES, PLEASE TELL US WHEN AND EXPLAIN____

Insurance status: (*Check one*) ☐ Currently Insured ☐ Medicaid ☐ No insurance If no insurance or high deductible insurance, would you like information about medical resources in the community?
(*Check one*) ❑ Yes ❑ No

HEALTH HISTORY:

I. PREGNANCY AND BIRTH
   A. PRENATAL
      1. When this child was born, how old was the mother?_____, father?_____
      2. Was this child born 1st, 2nd, 3rd, etc. (_____) of children?
      3. How long was this pregnancy?_________________________
      4. What was the baby's birth weight?______________________
      5. What kind of problems (bleeding, cramping, elevated blood pressure, etc.) or accidents, if any, happened during this pregnancy?__________________________
         ____
   B. PERINATAL
      1. How long was mother's labor?_______________ Were there any difficulties with the delivery?_____ If yes, what kinds?_____________________________________
      2. Was the baby delivered with forceps or by Caesarean Section?________________
      3. How long did the mother stay in the hospital after the birth?___________________
         Did the baby come home with the mother?_____
         If not, please explain.____
         ____
      4. Did the baby need oxygen after birth?_____________________________________
      5. Did the baby turn yellow enough to require treatment?_______________________
      6. Were there any other problems with the baby following birth?_________________
         If yes, please explain.____
         ____

II. DEVELOPMENTAL HISTORY

A. Children learn to do things at different ages. We need to know what each child already can do, or is learning to do easily, and where he/she might be slow and need help so that we can fit our program to each child. Listed below are some things children learn to do at different ages. Please indicate, as best you can remember, when your child started to do each.

	Earlier	When expected	Later	Age
Sit up without help				
Crawl				
Walk				
Talk				
Feed and dress self				
Learn to use the toilet				
Respond to directions				
Play with toys				
Use crayons				
Understand what is said to him/her				

B. Has anyone else in your family had any developmental or learning problems?________
If yes, please explain.____

III. SIGNIFICANT HEALTH PROBLEMS, ILLNESSES AND COMPLAINTS

A. HEALTH PROBLEMS

1. Is your child now under regular medical care for any condition?_______________
What is the medical diagnosis?____
What is the name of the health care provider (physician or other) who diagnosed this condition?____
When was this condition diagnosed?____

2. Is he/she currently taking any medication?__________
If so, what is the medication and dosage and how frequently is it given?_______
____

3. Does your child have any chronic problems such as:
Asthma_____ Seizures_____ Diabetes_____
Liver disease_____ Rheumatic fever_____ Bleeding tendencies_____
Allergy problems_____ Heart/blood vessel disease_____
Sickle cell disease_____ Other (Please list.)__________________________
If your child has allergy problems, please indicate symptoms (rash, itching, swelling, difficulty breathing, sneezing, etc.)________________________________
   a. When eating what foods, if any?______________________________________
   b. When taking what medications, if any?________________________________
   c. When near animals, furs, insects, dust, etc.?___________________________

4. Is your child frequently ill with such things as:
Colds_____ How often?____________________________
Ear infections_____ How often?____________________________
Urinary tract infections or problems_____
How often?____________________________
Other (Please list.)___________________________
How often?____________________________

5. Has your child had:
   Boils_____ Chicken pox_____ Eczema_____ Scarlet fever_____
   Whooping cough_____ RSV_____

B. PAST MEDICAL HISTORY

1. What operations (surgeries) has your child had—and when (date)?_________
   ____
2. Has your child every been hospitalized? If yes, when and for what reason?____
3. What injuries has he/she had that were serious enough for a doctor's care Serious illness, stitches, broken bones, etc.)? When did this occur?________
   ____
4. Has your child ever lost consciousness or had a head injury which required medical attention? If, yes, please explain.________________________________
   ____
   When did this occur?____

C. FAMILY HEALTH HISTORY

Please list the names and ages of blood relatives (immediate family) and what health problems each may have:

Name	Age	Relationship	Health problem(s)

IV. EXPLANATION OF HEALTH: Please discuss any health concerns or any conditions not previously noted that interfere with your child's everyday activities.

Did a physician or other heath professional tell you the child has this condition?__________ If yes, please indicate who and when.

I give permission for the health information contained in the above portion of this form to be shared with adults in the school setting that will be working with my child.

Date____________________ Signature of parent or guardian:_________________________________

(Please complete page 4.)

V. CURRENT HABITS AND OTHER BEHAVIOR

A. Does your child feed himself/herself well?____ With fingers?____ or silverware?____
Does he/she have any problems eating certain foods?_____________________________
Good or poor appetite?____________

B. How much sleep does he/she get at night?________________ Naps?________________

C. Does he/she dress himself/herself well___________ Does he/she pick out which clothes to wear?___________

D. When did he/she last wet the bed?____

E. Is he more or less active than other peers (friends the same age)?_________________

F. Does he tire easily?________________

G. What are your child's fears?____

H. Do you think your child daydreams excessively?_________________________________

I. Have there been any big changes in your child's life in the last six (6) months?
Yes_____ No_____ If yes, please describe______________________________________
____

J. Are you or your family having any problems now that might affect your child?
Yes_____ No_____ If yes, please describe.______________________________________
____

K. Is there anything else you would like us to know about your child?
Yes_____ No_____ If yes, please describe.______________________________________
____
____

VI. PERSONALITY TRAITS

A. Does your child cry easily?_____ What makes him/her cry?______________________
____

B. Does he/she frequently lose his/her temper?____________________________________

C. Does your child make friends easily?____

C. What does your child do for fun?
1. Indoors____
2. Outdoors____
Does he/she prefer to play indoors or outdoors?_________________________________