ELKHORN AREA SCHOOL DISTRICT
ELEMENTARY SCHOOL HEALTH HISTORY

Today's date:_____ School Attending:_____ Teacher:_____ Grade:_____
Name of child:_____ Sex:_____ Birthdate:_____/____/_____
Address:_____ Phone Number:(___)_____-_____
_____ Health Insurance: Yes No
Father's Name:_____ Mother's Name:_____
Other Children Age School/Grade Present Health
_____
_____
Family Physician:_____ Family Dentist:_____

PAST MEDICAL HISTORY		
OTHER ILNESSES	NO	YES
1. "Red"/"Hard" Measles		
2. German Measles (Rubella)		
3. Meningitis		
4. Chicken Pox _____(date)		
5. Scarlet Fever		
6. Rheumatic Fever		
7. Mumps		
8. Pneumonia		
9. Diabetes		
10. Streptococcal infection		
11. High Fever (104° for more than two days)		

ALLERGIES	NO	YES
Has your child ever had a problem with the following:		
1. Asthma		
2. Food Allergies		
3. Eczema		
4. Drug or medication		
5. Nose or eye allergy		
6. Severe reaction to insect bites		

GENERAL HEALTH	NO	YES
1. Has your child ever undergone tests for health problems?		
2. Has s/he been seen by a specialist?		
3. Is s/he under the care of a specialist now?		
4. Has your child ever reverted to wetting or soiling?		
5. Is wetting or soiling a present concern? Day or Night time?		

Please explain:

CHILDHOOD DISEASES	NO	YES
1. Has your child ever had convulsions or seizures?		
2. Has your child ever been hospitalized? (If yes, list dates & reasons)_____		
3. Other severe illnesses? (if yes, list dates, illness and treatment ___ _____		

IMMUNIZATIONS	NO	YES
Have they been completed?		

ACCIDENTS	NO	YES
1. Any serious accidents or injuries?		
2. Poisoned?		
3. Broken bones?		
4. Frequent accidents?		

GROWTH AND DEVELOPMENT				
1. Weight of child at birth?				
2. Was child full-term? If no, please explain_____	Yes	No		
3. Did you or this child experience any difficulty with birth? Explain_____	Yes	No		
4. Did this child require any special medical care or hospitalization at birth or during first month? Explain_____	Yes	No		
At what age did your child do the following:	Early	On Time	Late	
5. Sit alone				
6. Walk alone				
7. Say single word				
8. Use 2-3 word sentences				
9. Become toilet trained				

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II. PRESENT MEDICAL HISTORY

Has your child been to the doctor in the past year?_____ If yes, when:_____
Has your child been to the dentist in the past year?_____ If yes, when:_____
Has your child been to a counselor or mental health professional in the past year?_____ If yes, please explain:
_____

GENERAL	NO	YES
1. Does s/he have a good appetite?		
2. Does s/he eat too much?		
3. Does s/he have excessive thirst?		
4. Does s/he have sleep problems?		
5. Does s/he have too much or too little energy?		
6. Does s/he have any physical restrictions?		
7. Does s/he take medicine regularly?		

EARS, NOSE, THROAT	NO	YES
1. Does s/he have frequent earaches?		
2. Does s/he have hearing trouble?		
3. Does s/he have tubes in ears?		
4. Does s/he have frequent throat infections?		
5. Does s/he have swollen glands?		
6. Does s/he have a chronic hoarse voice?		
7. Does s/he have frequent nose bleeds?		
8. Does s/he have bad teeth such as brown spots or decay?		
9. Does s/he have any pain with his/ her teeth or sore or bleeding gums?		
10. Does s/he frequently have sores or blisters on their lips or mouth?		
11. Does s/he regularly get chapped lips or around their mouth?		

RESPIRATORY	NO	YES
1. Has s/he had 4 to 6 colds in a year?		
2. Does s/he get a severe cough with colds?		
3. Does s/he have trouble getting rid of a severe cough?		
4. Does s/he complain of difficulty breathing?		
5. Does s/he have asthma or wheezing?		

URINARY	NO	YES
1. Does s/he complain of a pain upon urination?		
2. Does the urine have a strong odor?		

SKIN	NO	YES
1. Does your child have problems with rashes?		
2. Does s/he bruise easily?		
3. Does s/he have any unexplained lumps or spots?		
4. Does s/he get hives or eczema?		

EYES	NO	YES
1. Does s/he have problems with their eyes?		
2. Does his/her eyes turn in or out when tired?		
3. Does s/he wear glasses?		
4. Have your child's eyes been checked by a professional? If yes, by whom:_____ Date:_____		

CARDIOVASCULAR	NO	YES
1. Does s/he have heart problems?		
2. Does your child's lips, hands, or fingers turn blue with hard playing?		
3. Does s/he tire easily?		

GASTROINTESTINAL	NO	YES
Does s/he have:		
1. Frequent stomachaches?		
2. Any food allergies? If so, list: _____		
3. Frequent diarrhea?		
4. Constipation?		
5. Frequent vomiting?		

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SKELETAL	NO	YES
1. Does s/he complain of pains in legs, arms, back or joints?		
2. Does s/he toe in or out, limp or walk in an unusual way?		
3. Does s/he have any back problems?		

NEUROLOGICAL	NO	YES
Does your child have:		
1. Seizures?		
2. Frequent dizzy spells?		
3. Tremors or twitches?		
4. Fainting spells?		
5. Frequent headaches?		
6. Blackout spells?		

MENTAL HEALTH	NO	YES
Are you concerned about:		
1. Anger		
2. Bed wetting		
3. Bad dreams		
4. Biting nails		
5. Thumb sucking		
6. Stammering or stuttering		
7. Nervous habits of any kind		
8. Irritability, easily upset		
9. Restlessness		
10. Day dreaming, preoccupied		
11. Glum, sulky, moody		
12. Wanting too much attention, comfort or support		
13. Feelings easily hurt		
14. Breath holding		
15. Contrary, stubborn, uncooperative		
16. Selfishness, inability to share		
17. Jealousy		
18. Bad temper, tantrums		
19. Lying		
20. Does your child require more discipline than expected		
21. Destroys things on purpose		
22. Harms animals on purpose		
23. Harms others on purpose		
24. Disobedient		
25. Clumsiness, awkwardness		
26. Speech difficulty		

NEUROMUSCULAR	NO	YES
1. Does s/he loose their balance in unusual ways?		
2. Does s/he have muscle jerks, tics, or unexplained movements?		
3. Does s/he have any body weakness?		
4. Does s/he have any unusual staring spells?		
5. Does s/he fall down more than most children?		
6. Is his/her walking rhythm unsteady?		

Parental comments on health of child, if necessary:_____		

This form is required for all new students upon entry into the Elkhorn Area School District. This form tells us that you, as parents or guardians, believe that your child is mentally and physically healthy and fully able to participate in all school activities. Please have your child's school physical and dental turned into the school office as soon as possible. If this information changes during the school year, please contact your child's school counselor or teacher. Thank you.

*The above information is confidential health information and can be shared with appropriate school personnel.

Parent Signature:_____ Date:_____

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