Kaukauna Area School District
Health & Developmental History—Confidential

Name _____ Birth Date _____Gender_____

Home address_____ Phone_____
Father's Name _____ Mother's Name _____

Student Lives with: Both parents Mother Father Other Adults

Person Completing Form _____ Date _____
Number of children in the family _____ This child's rank in family ___

NOTE: The following information will be placed in the child's confidential/health care file, and will not become part of the child's cumulative records.

1. Motor Development:

Child sat without support	_____ By 7 months	_____ After 7 months
Child stood alone:	_____ By 13 months	_____ After 13 months
Child walked alone:	_____ By 14 months	_____ After 14 months
	_____ Child walked without having crawled first.	

2. Language History:

Child spoke single words	_____ By 20 months	_____ After 20 months
Child began combining words into sentences:	_____ By 24 months	_____ After 24 months

____ Child does not seem to understand directions or questions.
____ Child cannot carry out two directions, one after the other, given simultaneously.
____ Child cannot retell recent events in approximate order of occurrence.
____ Friends/relatives do not seem to understand most of what child says.
____ There is a second language spoken at home.
_____ Child has noticeable speech problem (please explain): _____
_____

Compared to others of the same age, my child is:
_____ Very Talkative _____ Talkative ____ Silent and quiet

3. Current Concerns: (Check those that may apply)
____ My child frequently stumbles or falls when running or walking.
____ My child has difficulty playing with other children.
____ My child has difficulty following directions.
____ My child is more active than other children his/her age.
____ My child does not seem interested in learning (counting, colors, coloring, cutting).
____ None of the above

My child has:
____ Has no sleep problems
____ Difficulty settling down to sleep.
____ Up frequently at night.
____ Difficulty sleeping in his/her own bed.
____ Shorter than average hours of sleep per night.

My child has:
____ Good control most of the time.
____ Wetting accidents during the day. How often? ____
____ Soiling accidents during the day. How often? ____

My child is:
____ Easy to discipline.
____ Sometimes difficult to discipline.
____ Usually difficult and doesn't change no matter what I do.

My child's attention span is: _____ Short _____ Average _____ Long

Overall, I feel that my child:
____ Will be successful in school.
____ May have some learning difficulties in school.
____ May need some special help in school.
____ May have some significant behavior problems.
____ May have trouble adjusting emotionally to school.

Has your child been evaluated or received any special services (such as Speech or Language Therapy, Early Intervention Program Services, Occupational or Physical Therapy?

_____ YES _____ NO Please Explain _____

Has your child attended a preschool or day care center?

_____ YES _____ NO Number of years _____ Where _____

4. Pregnancy History of Mother for this Child:
What month of pregnancy did the mother first see a Doctor? _____
Age of mother at child's birth _____ Age of father at child's birth _____
How long was this pregnancy? ____
_____ Had Bleeding _____ Serious illness during pregnancy
_____ Infections/illness during pregnancy _____ Had Rh/similar blood problem
_____ Took medication other than vitamins _____ Tobacco Use
_____ Alcohol use _____ Drug use during pregnancy

Was your child adopted? _____ If so, at what age? _____

5. Birth History for this Child **Birth Weight _____**
____ Considered healthy
____ Labor longer than 24 hours ____ Had physical defect
____ Breech ____ Had C-Section
____ Baby in incubator after birth ____ Had difficulty breathing
____ Needed transfusion ____ Was jaundiced
____ Had medical problem (please explain) _____
_____

6. Health History:

____ Child has been seen by a doctor within the past year. Child's Doctor _____
____ Child has been seen by a dentist within the past year. Child's Dentist _____

Check any of the following your child has had or now has.

	YES	NO	WHEN		YES	NO	WHEN
ADD / ADHD				Joint problems / Arthritis			
Asthma				Kidney trouble			
Cancer				Mental illness			
Concussion				Migraines			
Diabetes				Frequent Nosebleeds			
Frequent Headaches				Seizures with fever			
Heart trouble				Seizures without fever			
Hepatitis				Skin conditions			
High blood pressure				Tuberculosis			
Frequent Indigestion				**Chicken Pox**			

List any medication that your child is taking. _____
_____

Allergies: Is your child allergic to any of the following? (Circle appropriate response)

Animals	YES / NO	Food	YES / NO	Medication	YES / NO
Bee stings	YES / NO	Latex	YES / NO	Seasonal	YES / NO

List specific allergies and explain what symptoms your child may experience as a result of these allergies: _____
If your child has allergies, is an Epi-pen required? YES / NO

7. Vision History:

____ I have concerns about my child's vision
____ My child has had a vision exam. List practitioner _____
____Child wears glasses
____ Shuts or covers one eye, tilts or thrusts head forward
____ Eyes appear to cross
____ Eyes move in jerky fashion
____ Complains of not seeing well
____ Rubs eyes
____ Blinks eyes frequently/squints
____ Unable to watch TV from a distance
____ Is sensitive to bright light
____ Family member color blindness
____ Family member with prescription glasses at young age.

8. Hearing History:

____ I have concerns about my child's hearing
____ My child has been seen by doctor for hearing concerns. List doctor(s) _____
____ My child has had his/her hearing tested. List practitioner _____
____ My child wears hearing aide(s)
____ Frequently does not hear directions.
____ Frequent colds/throat infections
____ Frequent ear infections/earaches-within the past year
____ When inside, child does not respond to noises from outside (car horn, dog barking, door bell, siren, etc.)

HAVE ANY OF THE FOLLOWING HAPPENED TO MEMBERS OF THE CHILD'S FAMILY (PERSONS THAT THE CHILD LIVES WITH OR USED TO LIVE WITH)?

____ Recent birth or other additions/changes in family.
____ Separation and/or divorce
____ Domestic violence
____ Recent move or history of frequent moves
____ Drinking problems or other drug abuse
____ Death of relative or close friend
____ Major physical illness or extended hospitalization
____ Depression, anxiety disorder or other psychological/psychiatric concerns
____ Physical, sexual or emotional abuse (This child? ____ yes ____ no)
____ Other (financial problems, significant behavior problems with other children, or other sources of major stress):_____
_____
_____
_____

IS THERE A HISTORY OF ANY OF THE FOLLOWING IN THE FAMILY (CHILD'S PARENTS, BROTHERS, SISTERS, GRANDPARENTS OR AUNTS/UNCLES)?

____ Speech or language disability
____ Depression, suicide, anxiety disorders or other psychological/psychiatric issues
____ Learning disability, reading disorders or similar difficulties
____ Attention deficit disorder and/or hyperactivity
____ Cognitive disability or retardation
____ Autism
____ Other concerns: _____
_____
_____

DO YOU HAVE A <u>YOUNGER</u> CHILD IN YOUR FAMILY THAT YOU HAVE CONCERNS ABOUT?

_____YES _____ NO CHILD'S NAME: _____
Birth date: _____

Please describe your concern:
_____
_____
_____

THANK YOU FOR YOUR PATIENCE AND COOPERATION IN FILLING OUT THIS FORM.

I, _____, give my permission to share this information with appropriate school employees for the purpose of addressing the health care or educational needs of this student. Date _____