

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 and Birth History for this Child:

How long was this pregnancy? ___

List and serious pregnancy complication _____

Birth Weight _____

___ Considered healthy
___ Had medical problem (please explain) _____

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

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 _____

___ I have concerns about my child's vision
___ My child has had a vision exam. List practitioner _____
___ Child wears glasses

___ 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)

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 health diagnosis			
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 Disease			

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

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
- ___ Substance 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: _____

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
- ___ Autism
- ___ Other concerns: _____

DO YOU HAVE A YOUNGER CHILD IN YOUR FAMILY THAT YOU HAVE CONCERNS ABOUT?

____ YES

____ NO

CHILD'S NAME: _____

Birth date: _____

Please describe your concern:

I verify that my child's health information is correct. I also give my permission for this health and emergency information to be shared with appropriate school personnel as needed. Furthermore, in the event of an emergency or illness, when I can't be reached, I authorize school personnel to notify and release pertinent health information to the listed emergency contact persons, physician, and or emergency medical services staff for my minor child. I also authorize treatment for my minor child in the event of a medical situation occurring during my absence when the medical provider is unable to contact me.

Signature of Parent/Legal Guardian _____ Date _____