Kaukauna Area School District
Health & Developmental History—<u>Confidential</u>

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? _____________________________

 Child's Name ______________________________

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)

 Child's Name ______________________________________

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: ____
____
____

Confidential page 4 **Child's Name ____**

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 _______________