GALLIPOLIS CITY SCHOOLS

CONFIDENTIAL HEALTH HISTORY

Parent: This information will be used to help us understand and work with your child. It is your privilege to omit any questions you find objectionable.

STUDENT'S NAME _____ Date of Birth _____

	FATHER	MOTHER
NAME		
DATE OF BIRTH		
GENERAL HEALTH		

Are parents living together? ☐ Yes ☐ No
Is there a stepparent living in the home? ☐ Yes ☐ No
Is there any other relative living in the home? ☐ Yes ☐ No
Child's Doctor _____
Doctor's Address _____
Names and ages of siblings: _____

_____

Have any of the children had any serious illnesses? ☐ Yes ☐ No
If yes, please explain. _____

_____

FAMILY HISTORY: Have any of the child's family members (including aunts, uncles, cousins) had any of the following health problems?

☐ Allergies ☐ Birth Defects ☐ Blindness ☐ Cerebral Palsy
☐ Deafness ☐ Diabetes ☐ Epilepsy/Seizures ☐ Mental Illness
☐ Mental Retardation ☐ Special Education ☐ Tuberculosis

If you checked any of the above, please explain: _____

_____

Have any of your children died? ☐ Yes ☐ No The cause? _____
Is this child adopted? ☐ Yes ☐ No At what age? ____ Does he/she know? ☐ Yes ☐ No

PREGNANCY AND BIRTH:

At what month of pregnancy did the mother first see a doctor? _____
Did the mother experience any illness or infection during pregnancy? ☐ Yes ☐ No
If yes, please briefly explain: _____
Did the mother experience unusual physical or emotional strain during pregnancy? ☐ Yes ☐ No
If yes, please briefly explain: _____
Was there exposure to alcohol, tobacco, or medications during pregnancy? ☐ Yes ☐ No
If yes, please briefly explain: _____
Length of Labor: _____ Birth Weight: _____ Birth Length: _____
Was infant full-term? ☐ Yes ☐ No Type of delivery? ☐ Natural ☐ Breach ☐ Caesarean
Was it necessary to give the baby oxygen? ☐ Yes ☐ No For how long? _____
Is this child a twin? ☐ Yes ☐ No Did the baby appear yellow? ☐ Yes ☐ No
Did the baby have difficulty breathing? ☐ Yes ☐ No
Was the baby in Intensive Care? ☐ Yes ☐ No Go home with mother? ☐ Yes ☐ No

In regard to your child's growth and development, did you have any special concerns about his/her crawling, walking, talking, toilet training, dressing himself/herself? For example, did he/she develop these skills early, late, or have much difficulty with them?

_____

_____

Has your child attended: ☐ Head Start ☐ Nursery School ☐ Kindergarten

GENERAL HEALTH:

Has your child had frequent attacks of earache or throat infections? ☐ Yes ☐ No

If yes, please explain: _____

Any trouble with urination? ☐ Yes ☐ No Bedwetting? ☐ Never ☐ Sometimes ☐ Often

Ever had a seizure (convulsion)? ☐ Yes ☐ No Please explain. _____

Is your child allergic to anything? ☐ Yes ☐ No If yes, what? _____

Has your child ever been in the hospital? ☐ Yes ☐ No Why? _____

Is your child currently taking any medication on a regular basis? ☐ Yes ☐ No

If yes, please explain/list. _____

Ever had a rash or hives? ☐ Yes ☐ No Caused by? _____

Ever had wheezing, asthma, or any other breathing problems? ☐ Yes ☐ No

If yes, please explain: _____

Ever had a serious head injury? ☐ Yes ☐ No

If yes, please explain. _____

Was child ever unconscious? ☐ Yes ☐ No For how long? _____

Has your child had any other serious accidents or injuries? ☐ Yes ☐ No

If yes, please explain. _____

Has your child ever had any of the following diseases?

☐ Allergies ☐ Asthma ☐ Chicken Pox ☐ Encephalitis
☐ Measles ☐ Meningitis ☐ Mumps ☐ Rheumatic Fever
☐ Scarlet Fever ☐ Tuberculosis ☐ Whooping Cough

Comments: _____

Does you child wear glasses/contacts? ☐ Yes ☐ No Hearing Aid? ☐ Yes ☐ No

Does your child have dental problems? ☐ Yes ☐ No Been to a dentist? ☐ Yes ☐ No

Date of last visit to the dentist? _____ Date of last visit to the doctor? _____

Does your child exhibit any behavior that concerns you (for example, thumb-sucking, nailbiting, more active than other children, difficulty sleeping, temper tantrums, excessive fear of anything, etc.)?

_____

Is there anything else we should know about your child to help make his/her school days easier?

_____

_____

_____ _____

Parent/Guardian Signature Date

"The Genetic Information Nondiscrimination Act of 2008 (GINA) prohibits employers and other entities covered by GINA Title II from requesting or requiring genetic information of an individual or family member of the individual, except as specifically allowed by this law. To comply with this law, we are asking that you not provide any genetic information when responding to this request for medical information. 'Genetic Information' as defined by GINA, includes an individual's family medical history, the results of an individual or family member's genetic tests, the fact that an individual or an individual's family member sought or received genetic services, and genetic information of a fetus carried by an individual or an individual's family member or an embryo lawfully held by an individual or family member receiving assistive reproductive services."

(7-17-12)