RANDOLPH COUNTY SCHOOLS
BASIC HEALTH HISTORY

CHILD'S NAME ______________________ BIRTH DATE __________ SEX ___ M ___ F ___

DOCTOR ______________________ DENTIST ______________________

I. Check any of the following conditions your child has or had:

___ 1. Allergies: seasonal, food, medications, insect bites (specify)
___ 2. Asthma
___ 3. Autism
___ 4. Bleeding/Clotting Problems
___ 5. Cancer
___ 6. Chicken Pox
___ 7. Developmental Defects
___ 8. Diabetes
___ 9. Emotional/Psychological Problems
___ 10. Fractures
___ 11. Frequent sore throats (3 or more a year)
___ 12. Heart Disease
___ 13. Hyperactive/ADD/ADHD
___ 14. Jaundice
___ 15. Kidney Infections
___ 16. Learning Disabilities
___ 17. Leukemia
___ 18. 3-day Measles (Rubella)
___ 19. 9-day Measles (Rubeola)
___ 20. Mentally Impaired
___ 21. Mumps
___ 22. Orthopedic Defect
___ 23. Recurring Ear Infections
___ 24. Rheumatic Fever
___ 25. Scarlet Fever
___ 26. Seizures - Last Seizure: __________
___ 27. Sickle Cell
___ 28. Premature Birth
___ 29. Toileting Problems
___ 30. Tuberculosis
___ 31. Whooping Cough
___ 32. Other Chronic Conditions? List ______________________

Please Explain:

____

____

____

II. GENERAL HEALTH OF CHILD

1. Have you ever suspected that your child has a hearing problem? Yes ___ No ___

   If so, why? ____

   Treatment Necessary: ______________________________________

2. Has your child had any problems with his speech? Yes ___ No ___

   If so, what kind? ____

   Treatment Necessary: ______________________________________

3. Has anything led you to think that your child may have a vision problem? Yes ___ No ___

   If so, what? ____

   Treatment Necessary: ______________________________________

4. Has your child ever been hospitalized: Yes ___ No ___ How Long? ____________

   If so, why? ____________

5. Does your child use prescribed medicines regularly? Yes ___ No ___

   If so, what? ____________

   Treatment Necessary: ____________

6. When was your child last seen by his doctor? ____________

   Name of doctor or clinic ____________

7. When was your child last seen by his dentist? ____________

   Name of dentist or clinic ____________

8. In general, how would you rate your child's health? (Circle one)

   Poor Not so good Average Very Good Excellent

9. Is your child on a special diet? Yes ___ No ___

   If so, what? ____________

10. Is your child restricted in physical activity? Yes ___ No ___

    If so, what? ____________

11. Is there anything your child's teacher should know about your child's health?

    Yes ___ No ___

    If so, what? ____________

12. Please list other family members (living under the same roof as the student)

Name	Age	Name	Age
1.		5.	
2.		6.	
3.		7.	
4.		8.	

13. Family History: Chronic health problems affecting other family members.

    ____

14. Special Services presently being provided by Community Agencies.

    ____

Parent's Signature ____________ Date ____________