SAINT PAUL SCHOOL

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SUBMIT AT YOUR CHILD'S KRI APPOINTMENT

HEALTH HISTORY QUESTIONNAIRE

Child's Name_____Birthdate_____Sex_____

Mother's Name_____ Father's Name_____

With whom does the child live?_____ Who is the legal guardian?_____

PERINATAL HISTORY

1. Did the mother and/or infant have any unusual problems/illness or complications during the pregnancy or the birth?

   _____Yes _____No If yes, explain briefly:_____

   _____.

2. Was this infant born full term _____ early _____ late_____?

   # of wks_____ # of days_____

3. What was this infant's birth weight?_____-

4. Did the infant have any sickness or problems while in the nursery? _____Yes _____No

   If yes, explain briefly:_____

   _____.

Please include both parent(s)/guardian(s) and all children:

NAME	BIRTH YEAR	SEX	NAME	BIRTH YEAR	SEX
1.			6.		
2.			7.		
3.			8.		
4			9		
5.			10.		

HEALTH CONDITIONS

PLEASE CHECK THE FOLLOWING HEALTH CONDITIONS AND ASSISTIVE DEVICES

_____Chickenpox Disease (what year?_____)

_____Diabetes

_____Eye Problems, poor vision, or crossed eyes

_____Glasses

_____Frequent ear infections

_____Tubes in ears

_____Hearing aid devices

_____Poor hearing

_____Frequent headaches

_____Frequent sore throat infections

_____Bladder or kidney disease

_____High Fevers

_____Seizures or epilepsy

_____Sickle cell disease

_____Prosthesis (specify) _____

_____Toothaches/dental infection

_____Dental devices (specify) _____

_____Poor sleep patterns

_____Frequent nosebleeds

_____Other? List below

_____Is your child sick a lot? If yes, please explain

_____

_____

ALLERGIES AND ASTHMA

1. Please list and describe **allergies** or **reactions to**:

   Medicines/drugs_____

   Foods/plants/others_____

   Bee or wasp stings_____

   Animals_____

2. Recommended **treatment** if allergy is severe:_____

   _____.

3. Does this child have asthma that has been diagnosed by a doctor? _____Yes _____No

   If yes, what **treatment** has been prescribed?_____

   _____.

INJURIES, ILLNESSES AND SURGERIES

Please list any severe injuries, illnesses or surgeries:

Injuries, Illnesses, Surgeries	Age of Child	If hospitalized, check here
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

ADDITIONAL INFORMATION

1. What medications are given daily?_____
2. What medications are given frequently, but not daily?_____

_____

3. Does this child receive allergy shots? If so, how often? _____
4. Will the child need to have medication(s) available at school? _____ If so, what medication(s) _____

_____

5. This child is usually: very active_____ normally active _____ rather active_____
6. Do any family members have long-term illnesses, such as diabetes or high blood pressure? If so, what?

_____.

Do you have any other comments or concerns about this child's health, development and/or behavior, family or home life of which you would like the school to be aware? If yes, please explain:

_____.

_____.

Completed by_____ Date_____

Relationship to child_____