WESTBOROUGH PUBLIC SCHOOLS
STUDENT HEALTH HISTORY Pre-K-Grade 3

Today's date: School Year:

Health History Informed Consent

The disclosure of student health information within the school is limited to the information necessary to serve the student's health or educational interest. Your signature is an informed consent to share this health history information with school staff on a need-to-know basis for academic success and emergency plans, as determined by the nurse.

______________________________ ______________________
Parent/Guardian signature **Date**

Student's Name ____________________Nickname__________ ☐ Male ☐ Female

Home Address: Street ______________________________ Apt. ________

City ____________________ State ____________ Zip __________

Phone (_____) ____________________ Date of Birth ______________

Who is completing this questionnaire? ☐ Mother ☐ Father ☐ Other: ______________

Doctor/NP/PA ______________________________ Phone ____________________

Dentist ______________________________ Phone____________________

Health Insurance ______________________________ Policy# ____________________

If you do not have health insurance, please contact the school nurse for information about Massachusetts programs.

FAMILY INFORMATION

Father's Name____

Home address: Street ______________________________ Apt. ___________
(If different from above)

City ____________________ State ____________ Zip ___________

Occupation ____________________ Work # (____)____________________

Cell/Pager # (___)____________________ Email: ____________________

Mother's Name ____

Home Address: Street ______________________________ Apt. ___________
(If different from above)

City ____________________ State ____________ Zip ___________

Occupation ____________________ Work # (____)____________________

Cell/Pager # (___)____________________ Email: ____________________

With whom does the child reside? ☐ Mother ☐ Father ☐ Other: ______________

Is there a family history of chronic illness, learning disabilities, health issues, etc? ☐ No ☐ Yes

If yes, please explain: ____

CHILD'S MEDICAL HISTORY

Were there any significant problems during pregnancy? ☐ No ☐ Yes

If yes, please explain: ____

Length of pregnancy: ________ weeks Birth weight: ______ lbs. ______ oz.

Were there any complications that occurred during or after birth? ☐ No ☐ Yes

If yes, please explain: ____

Is there any other information you'd like to share about this child's birth history? (i.e. adoption)

____

At what age did your child do the following: sit __________ crawl __________ walk __________

first word __________ sentence __________ toilet trained: day __________ night __________

Has your child ever had any significant injuries, illness, or hospitalizations? ☐ No ☐ Yes

If yes, please explain: ____

Does your child have any allergies? ☐ No ☐ Yes

If yes, please explain: ____

Please describe any other health concerns (i.e. asthma, diabetes, cardiac, seizures, psychiatric or behavioral concerns)

____

____

Has your child been evaluated for vision problems? ☐ No ☐ Yes

If yes, please explain: ____

Does your child wear glasses? ☐ No ☐ Yes

Has your child had frequent ear infections? ☐ No ☐ Yes

If yes, please explain: ____

Has your child ever been evaluated for hearing problems? ☐ No ☐ Yes

If yes, please explain: ____

Is your child presently taking any medications? ☐ No ☐ Yes - please indicate:

Name of Medication ____________________ Dose ________________ Time given _________

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Is this child presently under care of a physician, other than for regular check-ups? ☐ No ☐ Yes

If yes, please explain: ____

Are there any restrictions on this child's activities? ☐ No ☐ Yes

If yes, please explain: ____

Is there anything else about this child's health that you would like to share?

____

____

If we need to discuss any medical issues pertaining to this student, may we have permission to contact the child's health care provider? ☐ No ☐ Yes

If your child requires medicine or any special treatment while at school, please contact the school nurse. A signed order from a licensed prescriber and parental permission are required for ANY medicine or treatment given in school.

- I give permission for the nurse to provide minor first aid treatment which may include the application of antibiotic ointment or skin care products such as a mild cleanser, hand lotion, or lotion with Caladryl, Aloe, or Lidocaine.
- In case of accident or serious illness, I request that the school nurse contact me. If unable to reach me or one of my designees, I authorize the school to contact my child's medical provider. If needed, the school will call 911 and send my child with an adult from school to the hospital for emergency treatment. The school has no liability for medical costs.

______________________________ ______________________

Parent/Guardian signature Date

Student's Development History Questionnaire
2013-2014

Student Name: ______________________ Date of Birth: __________ today's date _______________

Siblings

Name/Relationship to Student	Age	Grade	School

Others living in the home (name and relationship):

____

____

School/Childcare History

Has your child attended school/childcare before? ☐Yes ☐No

Name of School/Provider	# Years Attended	# Days/Week	AM/PM

Has your child ever been screened or evaluated in the following areas:

☐Speech and Language ☐Fine/Gross Motor ☐Social/Emotional ☐Academic

Where? ____ Date___________________________

Has your child ever received Early Intervention services in the following areas?

☐Speech and Language ☐Fine/Gross Motor ☐Counseling ☐Social/Emotional ☐Academic

Where? ____ Date___________________________

Is your child currently on an IEP (Individual Educational Plan)? ☐Yes ☐No

Is your child currently on a 504 Plan? ☐Yes ☐No

Developmental Information

Does your child listen to stories read to him/her? ____

Does your child turn the pages of book and look at pictures? ________________________________

Does your child recall and retell stories or events? ______________________________________

Does he/she follow simple, 2-step directions? ____

Can your child express his/her thoughts and needs easily? __________________________________

What are your child's favorite activities? (toys, books, games, classes, etc.) ____________________

____

How many hours a day does your child spend watching TV/video games? ____________________

Favorite programs? ____

Does he/she sit very close to the TV? _________ Does he/she turn the volume up very high? _________________

Does he/she use crayons or markers to scribble or draw? ___________________________________

Hand preference: ☐Right ☐Left Explain (if necessary): ______________________________

Does he/she play with blocks, Lego's, or other construction toys without help? ______________________

What opportunities does your child have to play with other children? _________________________

____

____

Does your child talk with friends or relatives who come to visit? ______________________________

Does he/she enjoy playing alone? _______ Does he/she have an imaginary friend? ________________________

Will your child stay with a babysitter? ____

Is your child: highly active ____ moderately active _____ moderately quiet _____ very quiet _____

Please explain: ____

Can your child: ☐ tie ☐ zip ☐ button ☐ dress self ☐ care for own toileting needs

Please share any information about your child's sleeping patterns, eating habits, social/ behavioral style, learning style, fears, etc.

Do you have any concerns or comments about your child's transition to school?