COVENTRY PUBLIC SCHOOLS
COVENTRY, RI

HEALTH AND DEVELOPMENTAL HISTORY

Student's Name _____DOB_____Sex_____Grade____

Family Physician_____Address_____Phone_____

Perinatal & Developmental History

1. Did the mother have any unusual problems/illness during the pregnancy or the birth such as breech, forceps or cesarean delivery? Yes ____ No ____ If yes explain briefly: _____
   _____
2. Was the birth : full term ___ early ___ late ___
3. Child's birth weight: _____
4. Did the child have any sickness or problems after birth such as yellow jaundice, blue spells or convulsions? Yes ____ No ____ If yes explain briefly: _____
   _____
5. Does child wet or soil his/her pants? Yes ___ No ___ If yes please indicate: soiling___wetting ___
6. Does child wet the bed? Yes ___ No ___
7. How does this child's development compare to other children, such as brothers, sisters or playmate? About the same ___ slower ___ faster ___

Health Concerns

(Please check any which apply)

__ Eye problems, poor vision or crossed eye
__ Wears glasses/contacts
__ Frequent ear infections
__ Tubes in ears-what year(s) _____
__ Poor hearing
__ Wears hearing aid
__ Speech/language/problems
__ Frequent headaches/Migraines
__ Frequent nosebleeds
__ Prosthesis (indicate type) _____
__ Frequent colds
__ Problems paying attention/sitting still
__ Clumsiness in walking
__ Clumsiness in running
__ Difficulty using pencil/crayons
__ Difficulty with scissors
__ Temper tantrums
__ Overweight
__ Underweight

Injuries, Illness, Surgeries

Injuries, illness, surgeries (please list) Year Hospitalized

_____
_____
_____

(Please complete reverse side)

Significant Health History: Please indicate date child has had any of the following and circle any current conditions.

__ Allergies Type:_____
__ Anemia
__ Asthma
__ Birth Defects
__ Bleeding Disorder
__ Bone, joint or muscle problems
__ Chicken Pox
__ Diabetes
__ Eczema
__ Heart Disease
__ Functional Murmur
__ Congenital Disease
__ Hepatitis
__ Other (please indicate)_____

__ Bladder Problems
__ Kidney Disease
__ Lead Poisoning
__ Lyme Disease
__ Meningitis
__ Mononucleosis
__ Pneumonia
__ Poisoning/Overdose
__ Psoriasis
__ Rheumatic Fever
__ Scarlet Fever/Strep Throat
__ Seizure Disorder
__ TB (Tuberculosis)

Additional Information

Please indicate by a check if any of the following are necessary.

____ Daily medication (please indicate name of medication and reason for taking).
_____

____ Medical procedure (please indicate type and reason).
_____

____ Will medication(s) or procedure(s) be necessary in school? ___ Yes ___ No

Please check any of the following that apply.
____ Child evaluated at Child OutReach
____ Child evaluated for hearing and speech
____ Child enrolled at Head Start
____ Child enrolled in other education program _____
____ Previous school attended _____

Do you have any comments or concerns about this child's health, development, behavior, family or home life that you think might have an effect on your child in school? ___ Yes ___ No If yes, please explain. _____
_____
_____

I authorize the school nurse to share the health concerns and/or medical problems of my child with appropriate school personnel on a "need to know" basis.

Parent Signature _____ Date _____