NEW STUDENT MEDICAL HISTORY FORM

________________________ ________________________ ________________________
Last Name First Name Middle Name

Student's Birth Date: ______________________ Sex/Gender: _____Female _____Male

BIRTH & DEVELOPMENTAL HISTORY:

Student's birth was: (check all that apply)
___Single
___Multiple
___Caesarian (C-section)
___Premature
___Full term

Condition at Birth: _________________
Birth weight: ______________________
Birth length: ______________________
Adopted: At age: __________________

Age of child when he/she:

Crept: ______________________________
Began to Walk:_______________________
Said First Word:_____________________

Spoke First Sentence: _______________
Fed Self: __________________________
Completed Toilet Training: __________

What, if any, birth defects has your child had? ____

Does this limit his/her activity in any way? Explain: ____

HEALTH ISSUES: (If your child has had any of the following, state age condition occurred.)

Mumps____________________ Pneumonia___________________ Ear Problems____________________
Speech Problems___________ High Fever___________________ Frequent Ear Aches______________
Cerebral Palsy____________ Asthma______________________ Vision Problems_________________
Chicken Pox_______________ Heart Disease_______________ Wears Glasses___________________
Diabetes: ____Yes ___No Insulin Dosage: ____
Allergies-Describe: ____
Seizures: Describe seizure and date of last seizure: ____
____
Medications child taking: ____
____

Has your child ever been hospitalized? _____Yes ___No (If yes, answer the next 3 questions)
When/age? ______________________________ What for? _________________________________
For how long? ___________________________
Has your child ever had any serious accidents, broken bones, or stitches? ___Yes ___No
If yes, explain: ____

Does anyone in the family have vision with color deficiency? ___Yes ____No
If yes, whom:
____

PERSONAL RECORD:
Does your child experience any of the following? (Check all that apply)
___Seems overactive or restless ___Participate well with peers ___Has temper tantrums
___Has excessive fears ___Impulsive behavior ___Eats breakfast

Edited 3/23/17

Please provide any other pertinent information you feel may help us better care for your child on the back of this form!