

**SCOTCH PLAINS-FANWOOD PUBLIC SCHOOLS  
HEALTH PHYSICAL DEVELOPMENT HISTORY**

Date \_\_\_\_\_

This record is to be filled in by the parent or guardian and provided for the school nurse.

|                 |            |                 |           |     |
|-----------------|------------|-----------------|-----------|-----|
| LAST NAME       | FIRST NAME | INITIAL         | BIRTHDATE | SEX |
| ADDRESS         |            |                 | PHONE     |     |
| FATHER/GUARDIAN |            | MOTHER/GUARDIAN |           |     |

**PERSONAL HEALTH HISTORY**

|   |                          |                          |       |      |                           |                          |                          |       |        |                          |                          |       |            |                          |                          |       |                 |                          |                          |       |                    |                          |                          |       |                         |                          |                          |       |                       |                          |                          |       |                         |                          |                          |       |                      |                          |                          |       |                     |                          |                          |       |  |  |     |    |      |                     |                          |                          |       |                               |                          |                          |       |                          |                          |                          |       |           |                          |                          |       |                               |                          |                          |       |  |                          |                          |       |                                |                          |                          |       |                                   |                          |                          |       |   |                          |                          |       |                                  |                          |                          |       |                |  |  |  |                 |                          |                          |       |                |  |  |  |                 |                          |                          |       |                |  |  |  |
|---|--------------------------|--------------------------|-------|------|---------------------------|--------------------------|--------------------------|-------|--------|--------------------------|--------------------------|-------|------------|--------------------------|--------------------------|-------|-----------------|--------------------------|--------------------------|-------|--------------------|--------------------------|--------------------------|-------|-------------------------|--------------------------|--------------------------|-------|-----------------------|--------------------------|--------------------------|-------|-------------------------|--------------------------|--------------------------|-------|----------------------|--------------------------|--------------------------|-------|---------------------|--------------------------|--------------------------|-------|--|--|-----|----|------|---------------------|--------------------------|--------------------------|-------|-------------------------------|--------------------------|--------------------------|-------|--------------------------|--------------------------|--------------------------|-------|-----------|--------------------------|--------------------------|-------|-------------------------------|--------------------------|--------------------------|-------|--|--------------------------|--------------------------|-------|--------------------------------|--------------------------|--------------------------|-------|-----------------------------------|--------------------------|--------------------------|-------|---|--------------------------|--------------------------|-------|----------------------------------|--------------------------|--------------------------|-------|----------------|--|--|--|-----------------|--------------------------|--------------------------|-------|----------------|--|--|--|-----------------|--------------------------|--------------------------|-------|----------------|--|--|--|
| Birth weight _____ lbs. _____ oz.<br><br>Illness of mother during pregnancy<br>Born prematurely<br>Complications of delivery<br>Difficulty soon after delivery<br><br>Specify: _____<br><br>Walked alone when _____ months old<br><br>Said a few words when _____ months old<br><br>Has child had: <table style="width:100%; border-collapse: collapse;"> <tr> <td style="width:30%;"></td> <td style="width:10%; text-align:center;">YES</td> <td style="width:10%; text-align:center;">NO</td> <td style="width:10%; text-align:center;">DATE</td> </tr> <tr> <td>Serious bee sting allergy</td> <td align="center"><input type="checkbox"/></td> <td align="center"><input type="checkbox"/></td> <td>_____</td> </tr> <tr> <td>Hernia</td> <td align="center"><input type="checkbox"/></td> <td align="center"><input type="checkbox"/></td> <td>_____</td> </tr> <tr> <td>Chickenpox</td> <td align="center"><input type="checkbox"/></td> <td align="center"><input type="checkbox"/></td> <td>_____</td> </tr> <tr> <td>Rheumatic Fever</td> <td align="center"><input type="checkbox"/></td> <td align="center"><input type="checkbox"/></td> <td>_____</td> </tr> <tr> <td>Asthma or wheezing</td> <td align="center"><input type="checkbox"/></td> <td align="center"><input type="checkbox"/></td> <td>_____</td> </tr> <tr> <td>Pneumonia or bronchitis</td> <td align="center"><input type="checkbox"/></td> <td align="center"><input type="checkbox"/></td> <td>_____</td> </tr> <tr> <td>Frequent sore throats</td> <td align="center"><input type="checkbox"/></td> <td align="center"><input type="checkbox"/></td> <td>_____</td> </tr> <tr> <td>Frequent ear infections</td> <td align="center"><input type="checkbox"/></td> <td align="center"><input type="checkbox"/></td> <td>_____</td> </tr> <tr> <td>Trouble with hearing</td> <td align="center"><input type="checkbox"/></td> <td align="center"><input type="checkbox"/></td> <td>_____</td> </tr> <tr> <td>Trouble with speech</td> <td align="center"><input type="checkbox"/></td> <td align="center"><input type="checkbox"/></td> <td>_____</td> </tr> </table> |                          | YES                      | NO    | DATE | Serious bee sting allergy | <input type="checkbox"/> | <input type="checkbox"/> | _____ | Hernia | <input type="checkbox"/> | <input type="checkbox"/> | _____ | Chickenpox | <input type="checkbox"/> | <input type="checkbox"/> | _____ | Rheumatic Fever | <input type="checkbox"/> | <input type="checkbox"/> | _____ | Asthma or wheezing | <input type="checkbox"/> | <input type="checkbox"/> | _____ | Pneumonia or bronchitis | <input type="checkbox"/> | <input type="checkbox"/> | _____ | Frequent sore throats | <input type="checkbox"/> | <input type="checkbox"/> | _____ | Frequent ear infections | <input type="checkbox"/> | <input type="checkbox"/> | _____ | Trouble with hearing | <input type="checkbox"/> | <input type="checkbox"/> | _____ | Trouble with speech | <input type="checkbox"/> | <input type="checkbox"/> | _____ | Has child had: <table style="width:100%; border-collapse: collapse;"> <tr> <td style="width:60%;"></td> <td style="width:10%; text-align:center;">YES</td> <td style="width:10%; text-align:center;">NO</td> <td style="width:10%; text-align:center;">DATE</td> </tr> <tr> <td>Trouble with vision</td> <td align="center"><input type="checkbox"/></td> <td align="center"><input type="checkbox"/></td> <td>_____</td> </tr> <tr> <td>Frequent vomiting or diarrhea</td> <td align="center"><input type="checkbox"/></td> <td align="center"><input type="checkbox"/></td> <td>_____</td> </tr> <tr> <td>Tendency to bleed easily</td> <td align="center"><input type="checkbox"/></td> <td align="center"><input type="checkbox"/></td> <td>_____</td> </tr> <tr> <td>Allergies</td> <td align="center"><input type="checkbox"/></td> <td align="center"><input type="checkbox"/></td> <td>_____</td> </tr> <tr> <td>Convulsions or other seizures</td> <td align="center"><input type="checkbox"/></td> <td align="center"><input type="checkbox"/></td> <td>_____</td> </tr> <tr> <td>Unusual nervousness, nail biting, or thumb sucking</td> <td align="center"><input type="checkbox"/></td> <td align="center"><input type="checkbox"/></td> <td>_____</td> </tr> <tr> <td>Nightmares or trouble sleeping</td> <td align="center"><input type="checkbox"/></td> <td align="center"><input type="checkbox"/></td> <td>_____</td> </tr> <tr> <td>Breath-holding or temper tantrums</td> <td align="center"><input type="checkbox"/></td> <td align="center"><input type="checkbox"/></td> <td>_____</td> </tr> <tr> <td>Difficulty with toilet training or bedwetting</td> <td align="center"><input type="checkbox"/></td> <td align="center"><input type="checkbox"/></td> <td>_____</td> </tr> <tr> <td>Any severe injury or impairments</td> <td align="center"><input type="checkbox"/></td> <td align="center"><input type="checkbox"/></td> <td>_____</td> </tr> <tr> <td>Specify: _____</td> <td></td> <td></td> <td></td> </tr> <tr> <td>Any operations:</td> <td align="center"><input type="checkbox"/></td> <td align="center"><input type="checkbox"/></td> <td>_____</td> </tr> <tr> <td>Specify: _____</td> <td></td> <td></td> <td></td> </tr> <tr> <td>Any medication:</td> <td align="center"><input type="checkbox"/></td> <td align="center"><input type="checkbox"/></td> <td>_____</td> </tr> <tr> <td>Specify: _____</td> <td></td> <td></td> <td></td> </tr> </table> |  | YES | NO | DATE | Trouble with vision | <input type="checkbox"/> | <input type="checkbox"/> | _____ | Frequent vomiting or diarrhea | <input type="checkbox"/> | <input type="checkbox"/> | _____ | Tendency to bleed easily | <input type="checkbox"/> | <input type="checkbox"/> | _____ | Allergies | <input type="checkbox"/> | <input type="checkbox"/> | _____ | Convulsions or other seizures | <input type="checkbox"/> | <input type="checkbox"/> | _____ | Unusual nervousness, nail biting, or thumb sucking | <input type="checkbox"/> | <input type="checkbox"/> | _____ | Nightmares or trouble sleeping | <input type="checkbox"/> | <input type="checkbox"/> | _____ | Breath-holding or temper tantrums | <input type="checkbox"/> | <input type="checkbox"/> | _____ | Difficulty with toilet training or bedwetting | <input type="checkbox"/> | <input type="checkbox"/> | _____ | Any severe injury or impairments | <input type="checkbox"/> | <input type="checkbox"/> | _____ | Specify: _____ |  |  |  | Any operations: | <input type="checkbox"/> | <input type="checkbox"/> | _____ | Specify: _____ |  |  |  | Any medication: | <input type="checkbox"/> | <input type="checkbox"/> | _____ | Specify: _____ |  |  |  |
|   | YES                      | NO                       | DATE  |      |                           |                          |                          |       |        |                          |                          |       |            |                          |                          |       |                 |                          |                          |       |                    |                          |                          |       |                         |                          |                          |       |                       |                          |                          |       |                         |                          |                          |       |                      |                          |                          |       |                     |                          |                          |       |  |  |     |    |      |                     |                          |                          |       |                               |                          |                          |       |                          |                          |                          |       |           |                          |                          |       |                               |                          |                          |       |  |                          |                          |       |                                |                          |                          |       |                                   |                          |                          |       |   |                          |                          |       |                                  |                          |                          |       |                |  |  |  |                 |                          |                          |       |                |  |  |  |                 |                          |                          |       |                |  |  |  |
| Serious bee sting allergy   | <input type="checkbox"/> | <input type="checkbox"/> | _____ |      |                           |                          |                          |       |        |                          |                          |       |            |                          |                          |       |                 |                          |                          |       |                    |                          |                          |       |                         |                          |                          |       |                       |                          |                          |       |                         |                          |                          |       |                      |                          |                          |       |                     |                          |                          |       |  |  |     |    |      |                     |                          |                          |       |                               |                          |                          |       |                          |                          |                          |       |           |                          |                          |       |                               |                          |                          |       |  |                          |                          |       |                                |                          |                          |       |                                   |                          |                          |       |   |                          |                          |       |                                  |                          |                          |       |                |  |  |  |                 |                          |                          |       |                |  |  |  |                 |                          |                          |       |                |  |  |  |
| Hernia  | <input type="checkbox"/> | <input type="checkbox"/> | _____ |      |                           |                          |                          |       |        |                          |                          |       |            |                          |                          |       |                 |                          |                          |       |                    |                          |                          |       |                         |                          |                          |       |                       |                          |                          |       |                         |                          |                          |       |                      |                          |                          |       |                     |                          |                          |       |  |  |     |    |      |                     |                          |                          |       |                               |                          |                          |       |                          |                          |                          |       |           |                          |                          |       |                               |                          |                          |       |  |                          |                          |       |                                |                          |                          |       |                                   |                          |                          |       |   |                          |                          |       |                                  |                          |                          |       |                |  |  |  |                 |                          |                          |       |                |  |  |  |                 |                          |                          |       |                |  |  |  |
| Chickenpox  | <input type="checkbox"/> | <input type="checkbox"/> | _____ |      |                           |                          |                          |       |        |                          |                          |       |            |                          |                          |       |                 |                          |                          |       |                    |                          |                          |       |                         |                          |                          |       |                       |                          |                          |       |                         |                          |                          |       |                      |                          |                          |       |                     |                          |                          |       |  |  |     |    |      |                     |                          |                          |       |                               |                          |                          |       |                          |                          |                          |       |           |                          |                          |       |                               |                          |                          |       |  |                          |                          |       |                                |                          |                          |       |                                   |                          |                          |       |   |                          |                          |       |                                  |                          |                          |       |                |  |  |  |                 |                          |                          |       |                |  |  |  |                 |                          |                          |       |                |  |  |  |
| Rheumatic Fever   | <input type="checkbox"/> | <input type="checkbox"/> | _____ |      |                           |                          |                          |       |        |                          |                          |       |            |                          |                          |       |                 |                          |                          |       |                    |                          |                          |       |                         |                          |                          |       |                       |                          |                          |       |                         |                          |                          |       |                      |                          |                          |       |                     |                          |                          |       |  |  |     |    |      |                     |                          |                          |       |                               |                          |                          |       |                          |                          |                          |       |           |                          |                          |       |                               |                          |                          |       |  |                          |                          |       |                                |                          |                          |       |                                   |                          |                          |       |   |                          |                          |       |                                  |                          |                          |       |                |  |  |  |                 |                          |                          |       |                |  |  |  |                 |                          |                          |       |                |  |  |  |
| Asthma or wheezing  | <input type="checkbox"/> | <input type="checkbox"/> | _____ |      |                           |                          |                          |       |        |                          |                          |       |            |                          |                          |       |                 |                          |                          |       |                    |                          |                          |       |                         |                          |                          |       |                       |                          |                          |       |                         |                          |                          |       |                      |                          |                          |       |                     |                          |                          |       |  |  |     |    |      |                     |                          |                          |       |                               |                          |                          |       |                          |                          |                          |       |           |                          |                          |       |                               |                          |                          |       |  |                          |                          |       |                                |                          |                          |       |                                   |                          |                          |       |   |                          |                          |       |                                  |                          |                          |       |                |  |  |  |                 |                          |                          |       |                |  |  |  |                 |                          |                          |       |                |  |  |  |
| Pneumonia or bronchitis   | <input type="checkbox"/> | <input type="checkbox"/> | _____ |      |                           |                          |                          |       |        |                          |                          |       |            |                          |                          |       |                 |                          |                          |       |                    |                          |                          |       |                         |                          |                          |       |                       |                          |                          |       |                         |                          |                          |       |                      |                          |                          |       |                     |                          |                          |       |  |  |     |    |      |                     |                          |                          |       |                               |                          |                          |       |                          |                          |                          |       |           |                          |                          |       |                               |                          |                          |       |  |                          |                          |       |                                |                          |                          |       |                                   |                          |                          |       |   |                          |                          |       |                                  |                          |                          |       |                |  |  |  |                 |                          |                          |       |                |  |  |  |                 |                          |                          |       |                |  |  |  |
| Frequent sore throats   | <input type="checkbox"/> | <input type="checkbox"/> | _____ |      |                           |                          |                          |       |        |                          |                          |       |            |                          |                          |       |                 |                          |                          |       |                    |                          |                          |       |                         |                          |                          |       |                       |                          |                          |       |                         |                          |                          |       |                      |                          |                          |       |                     |                          |                          |       |  |  |     |    |      |                     |                          |                          |       |                               |                          |                          |       |                          |                          |                          |       |           |                          |                          |       |                               |                          |                          |       |  |                          |                          |       |                                |                          |                          |       |                                   |                          |                          |       |   |                          |                          |       |                                  |                          |                          |       |                |  |  |  |                 |                          |                          |       |                |  |  |  |                 |                          |                          |       |                |  |  |  |
| Frequent ear infections   | <input type="checkbox"/> | <input type="checkbox"/> | _____ |      |                           |                          |                          |       |        |                          |                          |       |            |                          |                          |       |                 |                          |                          |       |                    |                          |                          |       |                         |                          |                          |       |                       |                          |                          |       |                         |                          |                          |       |                      |                          |                          |       |                     |                          |                          |       |  |  |     |    |      |                     |                          |                          |       |                               |                          |                          |       |                          |                          |                          |       |           |                          |                          |       |                               |                          |                          |       |  |                          |                          |       |                                |                          |                          |       |                                   |                          |                          |       |   |                          |                          |       |                                  |                          |                          |       |                |  |  |  |                 |                          |                          |       |                |  |  |  |                 |                          |                          |       |                |  |  |  |
| Trouble with hearing  | <input type="checkbox"/> | <input type="checkbox"/> | _____ |      |                           |                          |                          |       |        |                          |                          |       |            |                          |                          |       |                 |                          |                          |       |                    |                          |                          |       |                         |                          |                          |       |                       |                          |                          |       |                         |                          |                          |       |                      |                          |                          |       |                     |                          |                          |       |  |  |     |    |      |                     |                          |                          |       |                               |                          |                          |       |                          |                          |                          |       |           |                          |                          |       |                               |                          |                          |       |  |                          |                          |       |                                |                          |                          |       |                                   |                          |                          |       |   |                          |                          |       |                                  |                          |                          |       |                |  |  |  |                 |                          |                          |       |                |  |  |  |                 |                          |                          |       |                |  |  |  |
| Trouble with speech   | <input type="checkbox"/> | <input type="checkbox"/> | _____ |      |                           |                          |                          |       |        |                          |                          |       |            |                          |                          |       |                 |                          |                          |       |                    |                          |                          |       |                         |                          |                          |       |                       |                          |                          |       |                         |                          |                          |       |                      |                          |                          |       |                     |                          |                          |       |  |  |     |    |      |                     |                          |                          |       |                               |                          |                          |       |                          |                          |                          |       |           |                          |                          |       |                               |                          |                          |       |  |                          |                          |       |                                |                          |                          |       |                                   |                          |                          |       |   |                          |                          |       |                                  |                          |                          |       |                |  |  |  |                 |                          |                          |       |                |  |  |  |                 |                          |                          |       |                |  |  |  |
|   | YES                      | NO                       | DATE  |      |                           |                          |                          |       |        |                          |                          |       |            |                          |                          |       |                 |                          |                          |       |                    |                          |                          |       |                         |                          |                          |       |                       |                          |                          |       |                         |                          |                          |       |                      |                          |                          |       |                     |                          |                          |       |  |  |     |    |      |                     |                          |                          |       |                               |                          |                          |       |                          |                          |                          |       |           |                          |                          |       |                               |                          |                          |       |  |                          |                          |       |                                |                          |                          |       |                                   |                          |                          |       |   |                          |                          |       |                                  |                          |                          |       |                |  |  |  |                 |                          |                          |       |                |  |  |  |                 |                          |                          |       |                |  |  |  |
| Trouble with vision   | <input type="checkbox"/> | <input type="checkbox"/> | _____ |      |                           |                          |                          |       |        |                          |                          |       |            |                          |                          |       |                 |                          |                          |       |                    |                          |                          |       |                         |                          |                          |       |                       |                          |                          |       |                         |                          |                          |       |                      |                          |                          |       |                     |                          |                          |       |  |  |     |    |      |                     |                          |                          |       |                               |                          |                          |       |                          |                          |                          |       |           |                          |                          |       |                               |                          |                          |       |  |                          |                          |       |                                |                          |                          |       |                                   |                          |                          |       |   |                          |                          |       |                                  |                          |                          |       |                |  |  |  |                 |                          |                          |       |                |  |  |  |                 |                          |                          |       |                |  |  |  |
| Frequent vomiting or diarrhea   | <input type="checkbox"/> | <input type="checkbox"/> | _____ |      |                           |                          |                          |       |        |                          |                          |       |            |                          |                          |       |                 |                          |                          |       |                    |                          |                          |       |                         |                          |                          |       |                       |                          |                          |       |                         |                          |                          |       |                      |                          |                          |       |                     |                          |                          |       |  |  |     |    |      |                     |                          |                          |       |                               |                          |                          |       |                          |                          |                          |       |           |                          |                          |       |                               |                          |                          |       |  |                          |                          |       |                                |                          |                          |       |                                   |                          |                          |       |   |                          |                          |       |                                  |                          |                          |       |                |  |  |  |                 |                          |                          |       |                |  |  |  |                 |                          |                          |       |                |  |  |  |
| Tendency to bleed easily  | <input type="checkbox"/> | <input type="checkbox"/> | _____ |      |                           |                          |                          |       |        |                          |                          |       |            |                          |                          |       |                 |                          |                          |       |                    |                          |                          |       |                         |                          |                          |       |                       |                          |                          |       |                         |                          |                          |       |                      |                          |                          |       |                     |                          |                          |       |  |  |     |    |      |                     |                          |                          |       |                               |                          |                          |       |                          |                          |                          |       |           |                          |                          |       |                               |                          |                          |       |  |                          |                          |       |                                |                          |                          |       |                                   |                          |                          |       |   |                          |                          |       |                                  |                          |                          |       |                |  |  |  |                 |                          |                          |       |                |  |  |  |                 |                          |                          |       |                |  |  |  |
| Allergies   | <input type="checkbox"/> | <input type="checkbox"/> | _____ |      |                           |                          |                          |       |        |                          |                          |       |            |                          |                          |       |                 |                          |                          |       |                    |                          |                          |       |                         |                          |                          |       |                       |                          |                          |       |                         |                          |                          |       |                      |                          |                          |       |                     |                          |                          |       |  |  |     |    |      |                     |                          |                          |       |                               |                          |                          |       |                          |                          |                          |       |           |                          |                          |       |                               |                          |                          |       |  |                          |                          |       |                                |                          |                          |       |                                   |                          |                          |       |   |                          |                          |       |                                  |                          |                          |       |                |  |  |  |                 |                          |                          |       |                |  |  |  |                 |                          |                          |       |                |  |  |  |
| Convulsions or other seizures   | <input type="checkbox"/> | <input type="checkbox"/> | _____ |      |                           |                          |                          |       |        |                          |                          |       |            |                          |                          |       |                 |                          |                          |       |                    |                          |                          |       |                         |                          |                          |       |                       |                          |                          |       |                         |                          |                          |       |                      |                          |                          |       |                     |                          |                          |       |  |  |     |    |      |                     |                          |                          |       |                               |                          |                          |       |                          |                          |                          |       |           |                          |                          |       |                               |                          |                          |       |  |                          |                          |       |                                |                          |                          |       |                                   |                          |                          |       |   |                          |                          |       |                                  |                          |                          |       |                |  |  |  |                 |                          |                          |       |                |  |  |  |                 |                          |                          |       |                |  |  |  |
| Unusual nervousness, nail biting, or thumb sucking  | <input type="checkbox"/> | <input type="checkbox"/> | _____ |      |                           |                          |                          |       |        |                          |                          |       |            |                          |                          |       |                 |                          |                          |       |                    |                          |                          |       |                         |                          |                          |       |                       |                          |                          |       |                         |                          |                          |       |                      |                          |                          |       |                     |                          |                          |       |  |  |     |    |      |                     |                          |                          |       |                               |                          |                          |       |                          |                          |                          |       |           |                          |                          |       |                               |                          |                          |       |  |                          |                          |       |                                |                          |                          |       |                                   |                          |                          |       |   |                          |                          |       |                                  |                          |                          |       |                |  |  |  |                 |                          |                          |       |                |  |  |  |                 |                          |                          |       |                |  |  |  |
| Nightmares or trouble sleeping  | <input type="checkbox"/> | <input type="checkbox"/> | _____ |      |                           |                          |                          |       |        |                          |                          |       |            |                          |                          |       |                 |                          |                          |       |                    |                          |                          |       |                         |                          |                          |       |                       |                          |                          |       |                         |                          |                          |       |                      |                          |                          |       |                     |                          |                          |       |  |  |     |    |      |                     |                          |                          |       |                               |                          |                          |       |                          |                          |                          |       |           |                          |                          |       |                               |                          |                          |       |  |                          |                          |       |                                |                          |                          |       |                                   |                          |                          |       |   |                          |                          |       |                                  |                          |                          |       |                |  |  |  |                 |                          |                          |       |                |  |  |  |                 |                          |                          |       |                |  |  |  |
| Breath-holding or temper tantrums   | <input type="checkbox"/> | <input type="checkbox"/> | _____ |      |                           |                          |                          |       |        |                          |                          |       |            |                          |                          |       |                 |                          |                          |       |                    |                          |                          |       |                         |                          |                          |       |                       |                          |                          |       |                         |                          |                          |       |                      |                          |                          |       |                     |                          |                          |       |  |  |     |    |      |                     |                          |                          |       |                               |                          |                          |       |                          |                          |                          |       |           |                          |                          |       |                               |                          |                          |       |  |                          |                          |       |                                |                          |                          |       |                                   |                          |                          |       |   |                          |                          |       |                                  |                          |                          |       |                |  |  |  |                 |                          |                          |       |                |  |  |  |                 |                          |                          |       |                |  |  |  |
| Difficulty with toilet training or bedwetting   | <input type="checkbox"/> | <input type="checkbox"/> | _____ |      |                           |                          |                          |       |        |                          |                          |       |            |                          |                          |       |                 |                          |                          |       |                    |                          |                          |       |                         |                          |                          |       |                       |                          |                          |       |                         |                          |                          |       |                      |                          |                          |       |                     |                          |                          |       |  |  |     |    |      |                     |                          |                          |       |                               |                          |                          |       |                          |                          |                          |       |           |                          |                          |       |                               |                          |                          |       |  |                          |                          |       |                                |                          |                          |       |                                   |                          |                          |       |   |                          |                          |       |                                  |                          |                          |       |                |  |  |  |                 |                          |                          |       |                |  |  |  |                 |                          |                          |       |                |  |  |  |
| Any severe injury or impairments  | <input type="checkbox"/> | <input type="checkbox"/> | _____ |      |                           |                          |                          |       |        |                          |                          |       |            |                          |                          |       |                 |                          |                          |       |                    |                          |                          |       |                         |                          |                          |       |                       |                          |                          |       |                         |                          |                          |       |                      |                          |                          |       |                     |                          |                          |       |  |  |     |    |      |                     |                          |                          |       |                               |                          |                          |       |                          |                          |                          |       |           |                          |                          |       |                               |                          |                          |       |  |                          |                          |       |                                |                          |                          |       |                                   |                          |                          |       |   |                          |                          |       |                                  |                          |                          |       |                |  |  |  |                 |                          |                          |       |                |  |  |  |                 |                          |                          |       |                |  |  |  |
| Specify: _____  |                          |                          |       |      |                           |                          |                          |       |        |                          |                          |       |            |                          |                          |       |                 |                          |                          |       |                    |                          |                          |       |                         |                          |                          |       |                       |                          |                          |       |                         |                          |                          |       |                      |                          |                          |       |                     |                          |                          |       |  |  |     |    |      |                     |                          |                          |       |                               |                          |                          |       |                          |                          |                          |       |           |                          |                          |       |                               |                          |                          |       |  |                          |                          |       |                                |                          |                          |       |                                   |                          |                          |       |   |                          |                          |       |                                  |                          |                          |       |                |  |  |  |                 |                          |                          |       |                |  |  |  |                 |                          |                          |       |                |  |  |  |
| Any operations:   | <input type="checkbox"/> | <input type="checkbox"/> | _____ |      |                           |                          |                          |       |        |                          |                          |       |            |                          |                          |       |                 |                          |                          |       |                    |                          |                          |       |                         |                          |                          |       |                       |                          |                          |       |                         |                          |                          |       |                      |                          |                          |       |                     |                          |                          |       |  |  |     |    |      |                     |                          |                          |       |                               |                          |                          |       |                          |                          |                          |       |           |                          |                          |       |                               |                          |                          |       |  |                          |                          |       |                                |                          |                          |       |                                   |                          |                          |       |   |                          |                          |       |                                  |                          |                          |       |                |  |  |  |                 |                          |                          |       |                |  |  |  |                 |                          |                          |       |                |  |  |  |
| Specify: _____  |                          |                          |       |      |                           |                          |                          |       |        |                          |                          |       |            |                          |                          |       |                 |                          |                          |       |                    |                          |                          |       |                         |                          |                          |       |                       |                          |                          |       |                         |                          |                          |       |                      |                          |                          |       |                     |                          |                          |       |  |  |     |    |      |                     |                          |                          |       |                               |                          |                          |       |                          |                          |                          |       |           |                          |                          |       |                               |                          |                          |       |  |                          |                          |       |                                |                          |                          |       |                                   |                          |                          |       |   |                          |                          |       |                                  |                          |                          |       |                |  |  |  |                 |                          |                          |       |                |  |  |  |                 |                          |                          |       |                |  |  |  |
| Any medication:   | <input type="checkbox"/> | <input type="checkbox"/> | _____ |      |                           |                          |                          |       |        |                          |                          |       |            |                          |                          |       |                 |                          |                          |       |                    |                          |                          |       |                         |                          |                          |       |                       |                          |                          |       |                         |                          |                          |       |                      |                          |                          |       |                     |                          |                          |       |  |  |     |    |      |                     |                          |                          |       |                               |                          |                          |       |                          |                          |                          |       |           |                          |                          |       |                               |                          |                          |       |  |                          |                          |       |                                |                          |                          |       |                                   |                          |                          |       |   |                          |                          |       |                                  |                          |                          |       |                |  |  |  |                 |                          |                          |       |                |  |  |  |                 |                          |                          |       |                |  |  |  |
| Specify: _____  |                          |                          |       |      |                           |                          |                          |       |        |                          |                          |       |            |                          |                          |       |                 |                          |                          |       |                    |                          |                          |       |                         |                          |                          |       |                       |                          |                          |       |                         |                          |                          |       |                      |                          |                          |       |                     |                          |                          |       |  |  |     |    |      |                     |                          |                          |       |                               |                          |                          |       |                          |                          |                          |       |           |                          |                          |       |                               |                          |                          |       |  |                          |                          |       |                                |                          |                          |       |                                   |                          |                          |       |   |                          |                          |       |                                  |                          |                          |       |                |  |  |  |                 |                          |                          |       |                |  |  |  |                 |                          |                          |       |                |  |  |  |

**FAMILY HEALTH HISTORY**

|                            |                          |                          |              |
|----------------------------|--------------------------|--------------------------|--------------|
| Has parent or sibling had: | YES                      | NO                       | Relationship |
| Significant Allergy        | <input type="checkbox"/> | <input type="checkbox"/> | _____        |
| Rheumatic Fever            | <input type="checkbox"/> | <input type="checkbox"/> | _____        |
| Heart Disease              | <input type="checkbox"/> | <input type="checkbox"/> | _____        |
| Diabetes                   | <input type="checkbox"/> | <input type="checkbox"/> | _____        |
| Tuberculosis               | <input type="checkbox"/> | <input type="checkbox"/> | _____        |
| Convulsive Disorder        | <input type="checkbox"/> | <input type="checkbox"/> | _____        |
| Mental Illness             | <input type="checkbox"/> | <input type="checkbox"/> | _____        |
| Cancer                     | <input type="checkbox"/> | <input type="checkbox"/> | _____        |
| Other                      | <input type="checkbox"/> | <input type="checkbox"/> | _____        |

**ADDITIONAL INFORMATION**

|  |                          |                          |                                      |
|--|--------------------------|--------------------------|--------------------------------------|
| Previous Schooling:                                      | YES                      | NO                       | Where? _____                         |
| Another Language Spoken at Home:                         | <input type="checkbox"/> | <input type="checkbox"/> | What? _____                          |
| Child born in the United States:                         | <input type="checkbox"/> | <input type="checkbox"/> | If no, years in United States? _____ |
| Other significant health issues/learning problems: _____ |                          |                          |                                      |