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

<table>
<thead>
<tr>
<th>LAST NAME</th>
<th>FIRST NAME</th>
<th>INITIAL</th>
<th>BIRTHDATE</th>
<th>SEX</th>
</tr>
</thead>
<tbody>
<tr>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>ADDRESS</th>
<th>PHONE</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>FATHER/GUARDIAN</th>
<th>MOTHER/GUARDIAN</th>
</tr>
</thead>
<tbody>
<tr>
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</tr>
</tbody>
</table>

### PERSONAL HEALTH HISTORY

- **Birth weight** ______ lbs. ______ oz.
- **Illness of mother during pregnancy**
  - [ ] YES
  - [ ] NO
- **Born prematurely**
  - [ ] YES
  - [ ] NO
- **Complications of delivery**
  - [ ] YES
  - [ ] NO
- **Difficulty soon after delivery**
  - [ ] YES
  - [ ] NO
- **Specify:** _________________________
- **Walked alone when** ____________ months old
- **Said a few words when** ____________ months old
- **Has child had/has:**
  - [ ] YES
  - [ ] NO
  - **Date:** ____________
  - **Serious bee sting allergy**
    - [ ] YES
    - [ ] NO
  - **Hernia**
    - [ ] YES
    - [ ] NO
  - **Chickenpox**
    - [ ] YES
    - [ ] NO
  - **Rheumatic Fever**
    - [ ] YES
    - [ ] NO
  - **Asthma or wheezing**
    - [ ] YES
    - [ ] NO
  - **Pneumonia or bronchitis**
    - [ ] YES
    - [ ] NO
  - **Frequent sore throats**
    - [ ] YES
    - [ ] NO
  - **Frequent ear infections**
    - [ ] YES
    - [ ] NO
  - **Trouble with hearing**
    - [ ] YES
    - [ ] NO
  - **Trouble with speech**
    - [ ] YES
    - [ ] NO
  - **Celiac Disease**
    - [ ] YES
    - [ ] NO
  - **Diabetes**
    - [ ] YES
    - [ ] NO
  - **Specify:** _________________________
  - **Any operations:**
    - [ ] YES
    - [ ] NO
    - **Specify:** _________________________
  - **Any medication:**
    - [ ] YES
    - [ ] NO
    - **Specify:** _________________________

### FAMILY HEALTH HISTORY

<table>
<thead>
<tr>
<th>Has parent or sibling had:</th>
<th>YES</th>
<th>NO</th>
<th>Relationship</th>
</tr>
</thead>
<tbody>
<tr>
<td>Significant Allergy</td>
<td>[ ]</td>
<td>[ ]</td>
<td></td>
</tr>
<tr>
<td>Rheumatic Fever</td>
<td>[ ]</td>
<td>[ ]</td>
<td></td>
</tr>
<tr>
<td>Heart Disease</td>
<td>[ ]</td>
<td>[ ]</td>
<td></td>
</tr>
<tr>
<td>Diabetes</td>
<td>[ ]</td>
<td>[ ]</td>
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</tr>
<tr>
<td>Tuberculosis</td>
<td>[ ]</td>
<td>[ ]</td>
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</tr>
<tr>
<td>Convulsive Disorder</td>
<td>[ ]</td>
<td>[ ]</td>
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</tr>
<tr>
<td>Mental Illness</td>
<td>[ ]</td>
<td>[ ]</td>
<td></td>
</tr>
<tr>
<td>Cancer</td>
<td>[ ]</td>
<td>[ ]</td>
<td></td>
</tr>
<tr>
<td>Other</td>
<td>[ ]</td>
<td>[ ]</td>
<td></td>
</tr>
</tbody>
</table>

### ADDITIONAL INFORMATION

- **Previous Schooling:**
  - [ ] YES
  - [ ] NO
  - **Where?** _________________________
- **Another Language Spoken at Home:**
  - [ ] YES
  - [ ] NO
  - **What?** _________________________
- **Child born in the United States:**
  - [ ] YES
  - [ ] NO
  - **If no, years in United States?** ____________
- **Other significant health issues/learning problems:** _________________________

Rev. 2009 / 2014