Manchester Board of Education Student Health/Developmental History
Saint James School

PLEASE PRINT Date: _____

Name of Child: _____ Sex: _____
Last First Middle

Address: _____ Grade Entering: _____

_____ Phone: _____

Place of Birth: _____ Date of Birth: _____ Verification: _____

Father's Name: _____ Mother's Name: _____

(Or Guardian): _____

Child Lives With: _____ Number of Children in Family: _____

Other Children in Family

Name (First & Last)	Age	Name (First & Last)	Age

Child's Physician

Name: _____

Address: _____

_____

Phone: _____

Child's Dentist

Name: _____

Address: _____

_____

Phone: _____

What does your child enjoy doing? _____

Describe your child in one sentence: _____

Has your child had a pre-school experience? _____ If yes, where? _____

Has your child received services from an organization such as Manchester Public Health Nursing, Newington Hearing Clinic, Child Guidance, etc.? _____

How does your child react in new situations? _____

How does your child respond to meeting new people? _____

Have there been any big changes in your child's life during the past year? _____

Birth Weight: _____ lbs. _____ oz. Length: _____ in.

	YES	NO	Please explain if YES:
1. Were there any illnesses during pregnancy?			
2. Was there consumption of alcohol, drugs, or smoking during pregnancy?			
3. Were there any problems during labor or delivery?			
4. Was your child premature?			
5. Were there any problems with your child after delivery?			
6. Did your child double his/her birth weight by age 1?			
7. Were there any problems the first year?			
8. Has your child ever had an accident or serious illness?			
9. Has your child ever been admitted to the hospital?			
10. Has your child had an operation?			
11. Has your child had any broken bones or serious burns?			
12. Has your child had a head injury or been knocked out?			
13. Has your child ever taken medicines or poisons accidentally?			

	YES	NO	Please explain if NO:
14. Did your child walk by 18 months?			
15. Did your child speak single words by age 1?			
16. Did your child speak in sentences by age 3?			
17. Do you understand most of your child's speech?			

System Review

	YES	NO	Please explain if YES:
1. Is your child allergic to anything? What type of reaction? Need for Epipen?			
2. Does your child have asthma?			
3. Has your child ever had an unusual reaction to an immunization?			
4. Does your child eat anything that is not food, such as starch, paint, or dirt?			
5. Does your child take medication regularly?			
6. Does your child have trouble seeing, or does he/she squint or have crossed eyes?			
7. Does your child wear glasses or is he/she supposed to wear glasses?			
8. Does your child have frequent ear infections?			
9. Does your child favor one ear or seem to have trouble hearing?			
10. Does your child have a persistently runny or stuffy nose?			
11. Does your child breathe through his/her mouth?			
12. Does your child have frequent colds, coughs, or sore throats?			
13. Does your child tire easily?			
14. Does your child have frequent stomach pain? Vomiting? Diarrhea? Constipation?			
15. Does your child wet or soil his/her pants?			
16. Does your child have any pain or weakness in his/her arms or legs, or does he/she limp?			
17. Does your child complain of frequent headaches?			
18. Does your child have trouble sleeping?			
19. Does your child have skin rashes?			
20. Does your child have any problems with his/her teeth or gums?			
21. Does your child wear any dental appliances?			
22. Are there any other medical problems with your child?			

FAMILY HEALTH HISTORY

1. A child's family includes parents, brothers and sisters, grandparents, aunts, uncles, and cousins. Please check if any of the following have occurred in the family, and, if so, to whom:

		TO WHOM:
☐	Allergy (specify)	_____
☐	Asthma	_____
☐	Blood Disease	_____
☐	Diabetes	_____
☐	Hearing	_____
☐	Heart Disease	_____
☐	Hypertension	_____
☐	Learning Disability	_____
☐	Rheumatoid Arthritis	_____
☐	Seizure Disorder	_____
☐	Speech	_____
☐	Tuberculosis	_____
☐	Other _____	_____

2. Please list any other information concerning your child's health which you feel would be helpful to the school:

_____

_____

_____

3. Do you have any other concerns about your child as he/she starts school?

_____

_____

_____

4. Please check any of the following areas in which you would like to see improvement made by your child:

☐	Feeding	☐	Thumb Sucking
☐	Toileting	☐	Playing
☐	Approaching People	☐	Listening
☐	Paying Attention	☐	Understanding Speech
☐	Controlling Temper	☐	Functioning Independently
☐	Walking or Moving	☐	Following Directions
☐	Sitting Still	☐	Talking
☐	Getting Along with Others	☐	Other: _____

Explain: _____

CURRENT FUNCTIONING

A. Relationship with teacher(s)

B. Relationship with peers

C. Ability to Function on:
    1. One-to-one basis

    2. Small group basis

    3. Large group basis

D. Any outside agencies involved (Juvenile Court, Child Guidance Clinic, etc.)

E. Social/emotional strengths (interests, leadership qualities, etc.)

F. Areas of concern (inappropriate behavior, self-image, etc.)

COMMENTS

Lead-Screening Questions:

1. Has your child ever lived in or regularly visited a house (such as the home of a friend or relative) built before 1978? Circle: Yes or No
2. Are there any areas of peeling or chipping paint visible in these houses? Circle: Yes or No
3. Has the dwelling ever undergone any renovation while your child was in residence or visiting? Circle: Yes or No
4. Are there any areas of bare soil around your house or outbuildings where your child plays? Circle: Yes or No
5. Does your child eat any unusual items such as dirt or soil? Circle: Yes or No

I AM AWARE THAT THE ABOVE DATA WILL BE PART OF MY CHILD'S PERMANENT RECORD.

Signature of Parent/Guardian: _____

Interviewer (if applicable): _____ Date: _____