TWIN SPRING FARM DAY SCHOOL

PLEASE RETURN TO TSF OFFICE **Before your child begins school**

NEW STUDENT HEALTH HISTORY

STUDENT'S NAME ____ Date _______________________

(Circle Answer)

A. PREGNANCY AND BIRTH

1. Was the mother's pregnancy accompanied by any special problems (required medications, exposed to toxic substances, etc.)? No Yes
2. Was the baby carried full term? No Yes
3. Was the birth accompanied with any difficulties? _________ No Yes
4. What was the baby's birth weight? ___________________ No Yes
5. Did the baby have any trouble following birth (require oxygen, incubator, extended stay, etc.)? No Yes

B. EARLY CHILDHOOD HISTORY

1. Would you describe the baby as average, quiet, or active? _________
2. Did the baby have any special problems in the first six months? ____ No Yes
3. At what age did the child sit alone without support? _________
4. Did the child crawl? _________
5. At what age did the child walk alone without support? _________
6. At what age did the child begin to say two or three words together? _________
7. If the child has stopped wetting the bed, at what age did he or she stop? _________

C. HEALTH HISTORY

1. Has the child ever been in a hospital or had an operation? No Yes

   When? What for? Name of hospital

   ____

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2. Does the child have a history of hypoglycaemia, diabetes, bronchitis, pneumonia, or any other illness? No Yes
3. Has the child ever had any serious accidents or broken bones? No Yes
4. Is the child taking any medicines or vitamins now? What for? No Yes

D. ANSWER THE FOLLOWING QUESTIONS:

1. Has the child ever had chicken pox? If yes, date _________ No Yes
2. Has the child ever had scarlet fever? No Yes
3. Has the child had more than six colds or throat infections accompanied by fever within a year? No Yes

		(Circle Answer)	
4.	Has the child had any trouble with ears or hearing?	No	Yes
5.	Has the child had any trouble with eyes or seeing.	No	Yes
6.	Has the child ever had any trouble with teeth?	No	Yes
7.	Has the child ever had a convulsion or fit?	No	Yes
8.	Has the child ever had a fainting spell?	No	Yes
9.	Has the child ever had a head injury?	No	Yes
10.	Has the child ever been unconscious?	No	Yes
11.	Does the child complain of headaches?	No	Yes
12.	Has a doctor ever said the child had a heart murmur?	No	Yes
13.	Does the child become tired easily?	No	Yes
14.	Do any foods disagree with the child?	No	Yes
15.	Does the child often have diarrhea?	No	Yes
16.	Has constipation ever been much of a problem for your child?	No	Yes
17.	Does the child complain of bellyaches?	No	Yes
18.	Does the child have any problem with urination?	No	Yes
19.	Does the child have any skin problems?	No	Yes
20.	Has the child ever had eczema or allergy?	No	Yes
21.	Has the child ever had asthma or wheezing?	No	Yes
22.	Has the child ever had an allergy or reaction to any medicines or injections? What was the medicine or injection? ________________________	No	Yes
23.	Does your child have an insect allergy? Is medication required? ________________	No	Yes
24.	Is your child currently receiving speech/language services?	No	Yes
	If yes, state where services are provided. ___________________		
	Has your child previously been seen by a Speech/Language Pathologist?	No	Yes
	If yes, please explain. ____		
25.	Is your child's speech easily understood by others?	No	Yes
	If not, check areas of difficulty: ____ **ARTICULATION** (sounds) _____ **LANGUAGE** (sentence patterns, vocabulary use, ability to understand directions, commands, ability to hold a conversation) ____ **VOICE** ____ **FLUENCY** (stuttering)		
26.	Has your child shown any hyperactivity during development	No	Yes
27.	Is child lethargic	No	Yes

Additional information that might be helpful to teacher in the classroom.

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PLEASE RETURN THIS FORM TO TSF OFFICE UPON RECEIPT