

STONEBROOKE CHRISTIAN SCHOOLS

Health History Report

DEVELOPMENTAL HISTORY

Child's Name: _____

Birth Parents Adoptive Parents Grandparents Guardian

Full-term pregnancy? Yes No If no, the number of months premature: _____

Birth complications? Yes No If yes, please describe: _____

Walked at _____ months Began talking at _____ months

PAST ILLNESSES

Please check those that your child has had, giving approximate dates:

Chicken Pox _____ Asthma _____

10-day Measles _____ Rheumatic Fever _____

Hay Fever _____ 3-day Measles _____

Epilepsy _____ Whooping Cough _____

Mumps _____ Poliomyelitis _____

Ear Infections _____ How many in the last year? _____

Please list any other serious or severe illnesses or accidents: _____

Please list any allergies (especially food) that staff should be aware of: _____

GENERAL INFORMATION

Does child sleep during the day? Yes No When? _____

Parent's evaluation of child's personality: _____

How does the child get along with parents, brothers, sisters and other children? _____

Has the child had group play experiences? Yes No Attended Pre-school? Yes No

Does the child have any special conditions or fears? _____

Is the child on any regular medications? If so, please describe _____

Parent Signature _____ Date _____