Warren County School District

Registration Student Health History

Name

Birth Date

Allergies

Medications

Pre-Natal Health History

Did the mother have any illness during the pregnancy? ..... ◯ **Yes** ◯ **No**

Did the mother take any medicines or drugs (other than vitamins) during pregnancy?.. ◯ **Yes** ◯ **No**

Did the baby come on time? ..... ◯ **Yes** ◯ **No**

Developmental History

Did the baby have any trouble while in the hospital? ..... ◯ **Yes** ◯ **No**

Did the baby have any special problems in the first six months? ..... ◯ **Yes** ◯ **No**

Can the child use the toilet without help? ..... ◯ **Yes** ◯ **No**

Family Health History (optional)

Choose any of the following diseases that this child's parents, grandparents, brothers, or sisters, have had :

☐allergy	☐hearing	☐heart disease
☐seizures	☐cancer	☐tuberculosis
☐vision	☐anemia	☐lead poisoning
☐asthma	☐blood disorder	
☐diabetes	☐learning problems	

Child's Health History

Has the child had any trouble with ears or hearing? ..... ◯ **Yes** ◯ **No**

Has the child had any trouble with eyes or seeing? ..... ◯ **Yes** ◯ **No**

Does the child wear glasses? ..... ◯ **Yes** ◯ **No**

Has the child had any trouble with teeth? . ..... ◯ **Yes** ◯ **No**

Has your child seen a dentist? ..... ◯ **Yes** ◯ **No**

Has the child ever had a convulsion (fit or seizure)? ..... ◯ **Yes** ◯ **No**

Does the child complain of headaches? . ..... ◯ **Yes** ◯ **No**

Has a doctor ever said the child had a heart problem? ..... ◯ **Yes** ◯ **No**

Has a doctor ever said the child had asthma? ..... ◯ **Yes** ◯ **No**

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Has a doctor ever said the child has diabetes? ..... ◯ **Yes** ◯ **No**

Has constipation ever been much of a problem for this child? ..... ◯ **Yes** ◯ **No**

Does the child have any skin problems / eczema? ..... ◯ **Yes** ◯ **No**

Has the child ever had asthma or wheezing? ..... ◯ **Yes** ◯ **No**

Has the child ever had an allergy or reaction to any medicines or injections? ..... ◯ **Yes** ◯ **No**

What was the medicine or injection?

Has the child ever complained of pain in the arms or legs? ..... ◯ **Yes** ◯ **No**

Has the child ever had swelling of any joints or had limping? ..... ◯ **Yes** ◯ **No**

List Other Health History Here

Any Surgeries or procedures _____

Diagnoses or Illnesses _____

Special Diet _____

Injuries or Broken Bones _____

Health History (continued)

Choose any of the following things which worry you about the child:

☐Bedwetting

☐Wetting during the day

☐Thumb sucking

☐Stammering or stuttering

☐High strung or easily upset

☐Too restless

☐Shy

☐Sad and sulky

☐Feelings easily hurt

☐Wanting too much attention

☐Day dreams

☐Wanting too much comfort from parent

☐Nightmares

☐Temper tantrums

☐Contrary or stubborn

☐Disobedient

☐Lying

☐Selfish in sharing

☐Jealous of brothers or sisters

☐Fighting with other children

☐Purposely destroys things

☐Feeding

☐Bowels

Does the child have any other special health needs or problems the school should know?

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