HEALTH & DEVELOPMENTAL HISTORY REPORT
Buckeye Union School District

Student Name________________________________________ Age ______ Birth Date ________________ Circle: M   F
School______________________________________________Grade_________Teacher_______________________

Please use the back of this form to provide details if necessary.

FAMILY HISTORY:
• Living with: Mother__ Father_____ Step-parent____ Other (Who?) ______________________________________
• Who lives at your home? Names and ages:__________________________________________________________________

PRENATAL HISTORY:
• Was this baby full term?__________ Premature?__________ How many weeks/months? ______________
• Complications (bleeding, illness, injury)______________________________________________________________
• Medication(s) taken during pregnancy   ________________________________________________________________
• Caffeine ________ Alcohol ____________ Smoking ________ Other _______________________________________

DELIVERY & NEONATAL:
• Labor (any problems, anesthesia) ________________________________________________________________
• Birth weight ____________Birth length  ___________ Type of birth: Vaginal ________ C Section ________
• Birth Complications: The baby was blue ___ Needed Oxygen ___ Had cord around neck ___Had jaundice ___
• Did the baby breathe right away? ________ Did the baby go home with mother? _______

DEVELOPMENT:
• Was your child’s development:  (A) average (L) Late or (E) Early for:  gross motor  (walking, running) ____,
  fine motor (coloring, using a spoon) __ , speech __ , self help (dressing, brushing teeth) _____, toilet training? ______

SOCIAL BEHAVIORAL HISTORY:
• Describe your child’s strengths ________________________________________________________________
• My child is:  Happy _____ Unhappy _____ Easy going _____ Difficult to live with _____ Explain:________________________
• What are your child’s activities outside of school? ______________________________________________________
• Does your child have friends at school? __________________________ At home? ___________________________
• What is his/her relationship with brothers/sisters? ______________________________________________________

INTERVENTIONS
• Did your child receive special programs (Circle which)?   Infant, ALTA, CCS, County, Speech, Occupational Therapy, Physical Therapy, Nursing, Other________________________________________________________

MEDICAL HISTORY:
• Did your child have any illnesses, hospitalizations, or surgeries?________________________________________
• Does your child have any physical defects or disabilities?
• Does/did your child have any of the following conditions? (Please circle all that apply)
  Asthma     Allergies     Ear infection     Seizures     High fever     ADD/ADHD
  Head injury or serious accident     Bowel/Bladder problems     Other:________________________________________________
  Please provide details including age and treatments for any conditions circled above:_____________________
• Is your child on medication now?_______ Name of medication_____________________________________
• Takes how much? _____________________ How often? __________________ Started when?_____________________

CURRENT HEALTH STATUS:
• How would you describe your child’s overall health?__________________________________________________
• Date of last physical exam_________________ Doctor_____________________________________________
• Date of last eye exam_________________ Doctor_____________________________________________
• Date of last dental exam_________________ Doctor_____________________________________________
• Any concerns not already mentioned?________________________________________________________________

Parent/Guardian completing form ( Print): ____________________________ Date________________________