WALL TOWNSHIP PUBLIC SCHOOLS
PARENT HEALTH QUESTIONNAIRE

Child's Name_____Birthdate_____Sex_____

Mother's Name_____ Father's Name_____

Address_____Home Phone_____

With whom does the child live?_____Who is legal guardian?_____

Name of Child's Doctor_____

Perinatal and Developmental History

1. Did the mother have any unusual problems/illness during the pregnancy or the birth, such as breech, forceps or caesarean delivery? Yes_____ No_____

   If yes, explain briefly:_____

2. Was this infant born full term_____ early_____late_____?

3. What was this infant's birth weight? _____

4. Did the infant have any sickness or problems while in the hospital, such as yellow jaundice, blue spells or convulsions? Yes_____ No _____

5. Please give approximate age at which the child: sat up alone:_____ walked:_____ said single words:_____ said sentences: _____ was toilet trained:_____

6. How does this child's development compare to other children, such as brothers, sisters or playmates?

   about the same_____ slower_____ faster_____

Health Conditions (please check any that this child has had)

_____chicken pox (what year? _____)

_____diabetes

_____eye problems, poor vision or crossed eyes

_____frequent ear infections

_____tubes in ears

_____toothaches/dental infection

_____frequent sore throat infections

_____is your child sick a lot?

_____high fever

_____poor hearing

_____seizures or epilepsy

_____sickle cell disease

_____frequent headaches

_____frequent nosebleeds

_____other? List

If yes, please explain:_____

_____ (page continues on back)

Allergies and Asthma

1. Please list and describe allergies or reactions to:
   Medicines/drugs_____
   Foods/plants/others_____
   Bee or wasp stings_____
2. Recommended treatment if allergy is severe: Allergy shots? _____
3. Does this child have asthma that has been diagnosed by a doctor? _____
   Yes_____ No_____ If yes, what treatment has been prescribed? _____

Injuries, Illnesses and Surgeries

Please list any severe injuries, illnesses or surgeries:

Injuries, illnesses or surgeries	age of child	if hospitalized check below
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Additional Information

1. What medications are given daily?_____
2. What medications are given frequently, but not daily?_____
3. This child is usually: very active_____ normally active_____ rather inactive_____
4. Do any family members have long-term illnesses, such as diabetes or high blood pressure?_____
   If so, what? _____

Do you have any other comments or concerns about this child's health, development, behavior, family or home life that you would like the school to be aware of? If yes, please explain: _____

_____

_____

Completed by:_____ Date:_____

Relationship to child:_____

I would like a conference with the school nurse: yes_____ No_____