Port Allegany Elementary School Student Health History

 Date: June 8, 2020

 Student Nam e:

1. Please check the box in front of any of the following things which worry you about the child.

Bedwetting or soiling Feelings easily hurt  Selfish in sharing

Wetting during the day  Wants too much attention Jealous of brothers or sisters

Inability to use toilet aloneWants too much comfort/supportFights with other children

Thumb sucking Day dreams Purposely destroys things

Stammering / stuttering Nightmares Eating habits

High strung/easily upset Temper Tantrums Lying

Too restless Contrary or stubborn Sad or sulky

Shy Disobedient

**Past History**

1. Check and date with the month and year any of the following illnesses the child has had.

”Red Measles” Date:       German or 3 day Measles Date:

Mumps Date:       Chicken Pox Date:

Whooping Cough Date:       Pneumonia Date:

Rheumatic Fever Date:

1. Has the child had any trouble with ears or hearing? Yes No
2. Has the child had any trouble with eyes or seeing? Yes No
3. Has the child had any trouble with teeth? Yes No
4. Has the child ever had a convulsion (seizure)? Yes No
5. Has the doctor ever said the child has a heart murmur? Yes No
6. Does the child have any skin problems? Yes No
7. Has the child ever had asthma or wheezing? Yes No
8. Has the child ever eaten paint/plaster or anything that is not food? Yes No
9. Has the child ever had an allergy or reaction to medicine / injections? Yes No

He / She is allergic to:

1. Has the child had any allergy or reaction to foods or other things? Yes No
2. Has the child ever been in the hospital or had an operation? Yes No

Month / Year of Operation       What for?       Name of Hospital

Month / Year of Operation       What for?       Name of Hospital

1. Has the child had any other illness, accidents, or broken bones? Yes No

Month / Year of incident       What was the problem?

Month / Year of incident       What was the problem?

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 Signature of Parent/Guardian

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