

# The CHILDREN'S School

## CHILD'S CONFIDENTIAL HISTORY FORM

(To be completed by parent)

In order to get to know your child better and help him/her develop to the fullest, we request the following information. This information will remain confidential. Please complete all questions, or as many as you wish to answer. Please send a picture of your child with this form.

1. Name(s) and age(s) of siblings (brothers and sisters):

\_\_\_\_\_

2. Does your child have a pet? \_\_\_\_\_ What kind? \_\_\_\_\_ Pet's name \_\_\_\_\_

3. Any significant difficulties during your pregnancy with the child who is enrolled in the Children's School? (If yes, describe.)

\_\_\_\_\_

4. Any significant difficulty during labor? (If yes, describe.)

\_\_\_\_\_

5. Any significant difficulty (health or other) with your child up until now? (If yes, describe.)

\_\_\_\_\_

6. Any allergies to medication or food?

\_\_\_\_\_

7. Any known or significant problems with your child's eyes, ears or speech?

\_\_\_\_\_

8. At what age did your child start: sitting up alone \_\_\_\_\_, crawling \_\_\_\_\_, walking \_\_\_\_\_, gibbering \_\_\_\_\_, speaking intelligibly \_\_\_\_\_.

9. Does your child have good eating habits? (If no, describe). \_\_\_\_\_

10. Does your child eat candy, other sweets or food with considerable amounts of sugar \_\_\_\_\_ regularly \_\_\_\_\_ occasionally \_\_\_\_\_ seldom \_\_\_\_\_

11. Do certain foods seem to affect your child's behavior? (If yes, explain.)

\_\_\_\_\_

12. Is this your child's first nursery school experience? \_\_\_\_\_

13. Has your child had much experience playing with other children? \_\_\_\_\_

14. Has your child had any difficulty interacting with other children? (If yes, explain.)

\_\_\_\_\_

15. Do you have difficulty leaving your child with others, a baby sitter? (If yes, explain.)

\_\_\_\_\_

16. Do you consider your child to be an observer \_\_, doer \_\_, non-verbal \_\_, verbal \_\_\_\_, very verbal \_\_\_\_, passive \_\_\_\_, aggressive \_\_\_\_, even tempered \_\_\_\_, active \_\_\_\_, very active \_\_\_\_, extremely active \_\_\_\_, quiet \_\_, very quiet \_\_, extremely quiet \_\_

17. Does your child have any fears? (If yes, describe.)

\_\_\_\_\_

18. Is there any additional information you would like us to know?

\_\_\_\_\_

19. What would you like your child to get out of his/her nursery school experience?

\_\_\_\_\_

You may feel confident that any information you share with the teacher will remain confidential. If during the year a crisis or any experience occurs in your child's life that could affect his/her physical or emotional behavior, please let us know. This form is due before your child may start school.

**HEALTH FORM IS DUE BEFORE THE FIRST DAY OF SCHOOL**  
**(Please fill in all information)**

Name of Child: \_\_\_\_\_ Sex: \_\_\_\_\_ Age: \_\_\_\_\_ Birthdate: \_\_\_\_\_  
Name of Parent/Guardian: \_\_\_\_\_  
Home Address: \_\_\_\_\_  
\_\_\_\_\_  
Phone: \_\_\_\_\_  
Business Address: \_\_\_\_\_  
\_\_\_\_\_  
Phone: \_\_\_\_\_  
Name of person to notify if parent/guardian cannot be reached (relationship) \_\_\_\_\_  
Address: \_\_\_\_\_ Phone: \_\_\_\_\_  
Family Physician: \_\_\_\_\_  
Address: \_\_\_\_\_ Phone: \_\_\_\_\_  
Insurance Company: \_\_\_\_\_ Policy/Cert. #: \_\_\_\_\_  
Religious Preference: \_\_\_\_\_

**PERMISSION TO TREAT:** In order that your child may be treated in an emergency, the following permission must be signed by parent/guardian. Parents will be informed of an emergency as soon as possible.

I hereby grant permission for the Student Health Service staff to examine and treat, hospitalize or secure proper treatment for my child.

Signature of parent/guardian: \_\_\_\_\_ Date: \_\_\_\_\_

**MEDICAL HISTORY:**

Is child in good health? \_\_\_\_\_ If not, give details: \_\_\_\_\_

Medicine to which child is sensitive or allergic: \_\_\_\_\_

Medicine child is taking regularly or needs to have on hand: \_\_\_\_\_

Has child had any of the following:	<u>Dates</u>		<u>Dates</u>
Rheumatic Fever	_____	Eye, ear, nose or throat problems	_____
Tuberculosis	_____	Hives, hay fever, allergies	_____
Asthma	_____	Bone or joint disease	_____
Diabetes	_____	High or low blood pressure	_____
Thyroid disease	_____	Liver disease, Hepatitis	_____
Emotional difficulty	_____	Stomach or bowel trouble	_____
Pneumonia, Pleurisy	_____	Kidney or urinary problems	_____
Heart disease, murmurs	_____	Epilepsy, convulsions	_____
Chicken Pox	_____		

List hospital admissions, operations and significant injuries, which dates: \_\_\_\_\_  
\_\_\_\_\_

Does child have a physical handicap? If so, explain: \_\_\_\_\_  
\_\_\_\_\_

Should nature and amount of physical exercise be limited? If so, explain: \_\_\_\_\_  
\_\_\_\_\_

Is there anything else we should know? \_\_\_\_\_

**TO BE COMPLETED BY PHYSICIAN:**  
**PROOF OF IMMUNIZATIONS (please list all dates)**

3 Doses of DPT _____	Date of last Tetanus _____
3 Doses of Polio _____	Measles _____
TB Test _____	Mumps _____
3 Doses of Hep. B _____	Rubella _____
Varivax _____	HIB _____
Meningitis Shot _____	Flu Shot _____

Last physical exam: \_\_\_\_\_

Medical history reviewed by physician: \_\_\_\_\_

Child is in good health and may participate in school programs: \_\_\_\_\_

**PHYSICIAN'S SIGNATURE & OFFICE STAMP:** \_\_\_\_\_ **DATE:** \_\_\_\_\_