

**COUNCIL ROCK SCHOOL DISTRICT**  
 Bucks County, Pennsylvania  
**Family Health History**

Child's Name \_\_\_\_\_ M \_\_\_ F \_\_\_ Birth Date \_\_\_\_\_

Address \_\_\_\_\_

Telephone \_\_\_\_\_

Father's Name \_\_\_\_\_ Mother's Name \_\_\_\_\_

Family Doctor \_\_\_\_\_ Telephone \_\_\_\_\_

Name of Pre-School Program \_\_\_\_\_

**CHILD'S HISTORY**

Does your child have:	<u>Yes</u>	<u>No</u>	Has your child had:	<u>Yes</u>	<u>Date(yr)</u>
Allergies	___	___	Chickenpox	___	_____
Asthma	___	___	Febrile Convulsions	___	_____
Ear Infections	___	___	Hepatitis	___	_____
Convulsions	___	___	Measles, German	___	_____
Frequent Colds	___	___	Measles, Regular	___	_____
Frequent Sore Throats	___	___	Mononucleosis	___	_____
Speech Difficulties	___	___	Mumps	___	_____
Vision Problems	___	___	Polio	___	_____
Other Concerns _____			Rheumatic Fever	___	_____
Is your child on any medications? ___	___	___	Scarlet Fever	___	_____
List Medications _____			Whooping Cough	___	_____
			Other	___	_____

Did mother have measles or other serious illness during pregnancy? \_\_\_ Was oxygen administered to your child at birth? \_\_\_ Any serious illnesses or surgery? \_\_\_ If yes, what? \_\_\_\_\_

Is your child under medical treatment? \_\_\_ If yes, explain \_\_\_\_\_

State any other information which would aid the school in a better understanding of your child.

**Family History**

Is there a history of:	<u>Yes</u>	<u>Relationship</u>
Allergies	___	_____
Asthma	___	_____
Color Deficiency (Blindness)	___	_____
Convulsive Disorders	___	_____
Diabetes	___	_____
Hearing Disorders	___	_____
Reading Disorders	___	_____
Tuberculosis	___	_____
Visual Disorder	___	_____
Other	___	_____

**Child's Developmental History**

Birth Weight	_____
Age Walked	_____
Age Talked	_____
Age Toilet Trained	_____
Age Stopped Bed-Wetting	_____

27 (6/95) Date \_\_\_\_\_ Signature of Parent/Guardian \_\_\_\_\_