



HEALTH HISTORY FORM 2007 - 2008

HEALTH HISTORY

Please indicate any serious illness or accidents, surgeries and / or any hospitalizations within the last three years.

Does your child wear glasses? _____ If Yes, how long has your child worn them? _____

Does your child sometimes cover one eye or tilt his/her head to one side while reading or watching TV? _____

Does your child complain of vision problems or frequent headaches? _____

Describe: _____

When was last eye exam? _____ By Whom? _____

Results of Exam? _____

Has your child had any hearing difficulties? _____

Describe: _____

When was last hearing exam? _____ By Whom? _____

Results of Exam? _____

Does your child presently have any health problems? _____ Please Explain: _____

When was last physical exam? _____ By Whom? _____

Is your child on any medication? _____ Describe: _____

If your child has any continuing health, vision or hearing problems which may affect school performance or attendance, please provide us with a report from you child's doctor.

BEHAVIOR, ATTITUDES AND INTERESTS

Does your child have many friends his/her own age? _____

How does s/he get along with other children? _____

How does s/he get along with his/her sibling(s)? _____

How does s/he get along with his/her parents? _____

Does your child have any special talents, skills or abilities? _____

Is your child having any major problems, which you feel need immediate attention? _____

Are there any family or home problems, which may affect this child's performance? _____

SIGNED: _____ DATE: _____