PVSD PERMANENT HEALTH HISTORY *(Confidential)*

Name______________________________ Sex: ❑ M ❑ F **Birthdate**________

Child's Physician________________________
Address____________________________________
Phone Number______________________________

Child's Dentist ________________________
Address ___________________________________
Phone Number _____________________________

Child's Physicians (Specialists) __________
____

Medical History (Past or present)

Accidents__________________________________
____
Operations _________________________________
____
Hospitalization _____________________________
When/Where ________________________________
____
____

Please check all that apply:

- ❑Allergies
- ❑Asthma
- ❑Diabetes
- ❑Heart Disorders
- ❑Seizures
- ❑ADD/ADHD
- ❑Handicapped
- ❑Hearing Concerns
- ❑Vision Concerns
- ❑Cancer
- ❑Immunosuppressed
- ❑Other Health Concerns________

If Allergies are checked above check all that apply:

- ❑Hay Fever
- ❑Peanut
- ❑Bee Sting
- ❑Food ______________
- ❑Drug______________
- ❑Other______________

Drug reactions ______________________________________
Name Drugs

Takes medication at home? **Yes ❑ No❑**
Name of Medication ___________________________________

Will be taking medication at School? **Yes ❑ No❑**
Name of Medication______________________

Any health problems during child's first five years?
____

Developmental History:

When did your child?	A*pproximate age*
Sit alone	
Say words	
Crawl	
Walk	
Use 2/3 word sentences	
Toilet train	

Does your child have now or in the past had, difficulties in any of these areas? Yes/No
Please explain below

Frequent health complaints? ______________________
Appear restless or overactive?______________________
Present any problem in discipline? _________________
Problems getting along with others? ________________

Please check all that apply:

- ❑Eating problems
- ❑Sleeping problem
- ❑Speech problems
- ❑Vision problems
- ❑Wears glasses
- ❑Hearing problems
- ❑Hearing Aid

Social Development: *(Yes or No)*

Plays alone? Yes ❑ No ❑
Plays with neighborhood children? Yes ❑ No ❑
Attended pre-school? Yes ❑ No ❑

Anything else you would like the school to know about your child:_______________________________
____

_______________________________________ _______________________________
Parent/Guardian Signature Date