Social-Medical History

School Health Services-Dedham Public Schools

The information you provide on this form is confidential and will be made known only to personnel involved in the education of your child.

Date: _____ School: _____

Information provided by: _____ Relationship to student_____

FAMILY HISTORY

Student Name: _____ Date of Birth_____ Sex: (circle) M F

Address: _____

Telephone: Home_____Cell_____Work_____

Father's Name:_____Occupation:_____

Mother's Name: _____Occupation:_____

Child is now living with (circle one): Both parents Father Mother Foster Parents Guardian

If applicable, Guardian's Name: _____

Children in family, including this student:

Name	Birthday	Sex

Others living in the home:_____

Primary language spoken at home: _____

Last school attended: _____

Student's Physician: _____Tel #_____

Student's Dentist:_____Tel #_____

HEALTH PROFILE

Student's overall health (circle one): Excellent Good Fair Poor

Please explain if necessary:_____

Any unusual circumstances with the pregnancy or delivery of this child?_____

Any unusual circumstances with the growth and development of this child?_____

Does this child have a history of?

- Hospitalizations/surgery (if yes please list reasons and dates): Yes No _____
  _____
- Seizures (if yes, explain if fever related or other causes): Yes No _____
  _____
- Illnesses (ie frequent strep throat, ear infections etc): Yes No _____
  _____
- Allergies (if yes, explain if food, medication, environmental): Yes No _____
  _____

Is this child currently on any medication (If yes please list medications and dosage) Yes No

_____

Does this child display signs of difficulty in the following areas? (Circle all that apply)

Vision Sleeping Expressing him/herself Hearing Eating
Maintaining attention Speech Following directions Getting along with peers
If circled, please explain_____
_____

Is this student able to participate in the regular physical education program? Yes No
If no, please explain:_____
Has this child experienced prolonged separations? Losses? Deaths? Yes No
If yes, please explain:_____
Please add any additional information that you feel would be helpful to us:_____
_____

DEVELOPMENTAL HISTORY

Did this child require any special medical care at birth and/or within the first months? Yes No (if yes, please explain):_____

Please indicate the approximate age at which your child reached the following developmental milestones: sat alone_____ used single words_____ crawled_____

walked_____ used full sentences_____ fed self_____

rode tricycle_____ toilet trained (day)_____ toilet trained (night)_____

Any additional information_____

MOTOR DEVELOPMENT

Does your child have any difficulty in accomplishing the following tasks? (circle one)

- Holding a crayon? Yes No
- Drawing lines? Yes No
- Using alternate feet walking up and down stairs? Yes No
- Using a zipper? Yes No
- Cutting with scissors? Yes No
- Fastening buttons? Yes No
- Catching a ball? Yes No

Describe this child's pattern of movement (i.e. awkward, agile, quick, hesitant) _____

_____

Which hand does your child use for most tasks? (circle one) Right Left

EMOTIONAL DEVELOPMENT

Separation: Does your child become upset when away from you for a few hours? Yes No

Socialization: Is your child hesitant or afraid to mix with other children? Yes No

Self-control: Does your child display strong reactions to discipline (i.e. temper tantrums) Yes No

Please describe your child's personality (i.e. outgoing, shy, cries easily, aggressive, talkative, quiet, fearful): _____

_____