TRUMBULL PUBLIC SCHOOL
Trumbull, Connecticut
DEPARTMENT OF SCHOOL HEALTH SERVICES

DATE_______________________

Name of Child____Date of Birth________________
Your child's medical history information can be helpful in understanding your child's educational needs. If you have any difficulty in accurately completing some of the information, you may wish to discuss it further with the appropriate school personnel.

FAMILY MEDICAL HISTORY Is there any family history of significant health issues, i.e. allergies, asthma, diabetes, seizures? Please list	☐Yes	☐No
PRENATAL HISTORY Was the pregnancy with this child normal? If there were problems please explain.	☐Yes	☐No
BIRTH HISTORY Hospital at which child was born____________________City/State ____________________ Were there any problems during labor or delivery? Please explain. Birth Weight: ______________ lbs. ______________ oz. Hospital Stay: Child days Mother days	☐Yes	☐No
INFANCY As an infant this baby was: ☐ Quiet ☐ Average ☐ Irritable ☐ Overactive Sleep Habits: ☐ Slept Well ☐ Hardly Slept ☐ Never Napped ☐ Slept Restlessly Feeding Problems: ☐ Sucking ☐ Swallowing ☐ Feeding ☐ Food Sensitivity (Allergy) Comments	☐ Yes	☐ No
DEVELOPMENTAL HISTORY **MOTOR** Sat alone without support ______________ Crawled ______________ Walked Alone ______________ Rode Tricycle **BOWEL & BLADDER TRAINING** Toilet Trained at what age: Bowel ______________ Bladder ______________ Problem with bedwetting?	☐ Yes	☐ No
Check if appropriate: ☐ Trips easily ☐ Runs into things ☐ Seems clumsier than others ☐ Excessive trouble with stairs ☐ No fear of climbing ☐ Afraid of climbing ☐ Climbs poorly ☐ Other		
HEARING & LANGUAGE Said First Words ____________Spoke 2-3 word sentences ____________Used Plurals____________		
Have you ever suspected any hearing problems?	☐ Yes	☐ No
Has your child had any ear infections?	☐ Yes	☐ No
If yes, approximately how many and how frequent? ______________________		
Has your child had ear surgery?	☐ Yes	☐ No
If yes, what type? ______________________		
Has your child's hearing been tested?	☐ Yes	☐ No
If yes, when? ______________________ By whom? ______________________		
Does your child have a known hearing loss?	☐ Yes	☐ No
Does your child wear a hearing aid?	☐ Yes	☐ No
Does your child speak clearly?	☐ Yes	☐ No
VISION Has your child's vision been checked? Date of Last Exam ______________________	☐ Yes	☐ No
Does your child have a known problem with vision?	☐ Yes	☐ No
Does your child wear glasses? Why were glasses prescribed?	☐ Yes	☐ No

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Trumbull, Connecticut

	Date of Last Exam
Child's Doctor ______	______
Address ______	
Child's Dentist ______	Date of Last Exam
Address ______	______

CHILD'S MEDICAL HISTORY		
Is your child currently being treated for any illness or condition of which the school should be aware? Describe:	☐ Yes	☐ No
Is your child presently taking any medication? Describe medication: Name, dosage, and frequency. Who prescribed medication & reason?	☐ Yes	☐ No
Does your child have any allergies? Please list. Medication ______ Food ______ Environmental	☐ Yes	☐ No
Is your child allergic to bee stings? Describe reaction & treatment ______ ______	☐ Yes	☐ No
Has your child been hospitalized during his/her infancy or pre-school years? Age ______ Reason for hospitalization & length of stay ______ ______	☐ Yes	☐ No
Does your child run high fevers?	☐ Yes	☐ No
Does your child have a history of seizures/convulsions? ☐ With high fever ☐ After an accident, i.e. head trauma ☐ No apparent cause Type of seizure:	☐ Yes	☐ No
Does your child have any orthopedic problems? If yes, explain and include any special equipment the child requires, and any limitation of activity.	☐ Yes	☐ No
Is there anything, not covered in this history, you would like us to know about your child?	☐ Yes	☐ No