Pendleton School District 16R
Health, Developmental, and Social History
CONFIDENTIAL
For Educational Purposes Only

Student's Name: ______________________ Birth Date: __________ Age: __________
Address: ______________________ Home #: __________
Student Lives With: ______________________ Number of Children in Family: __________
Parents are: _____ Married _____ Divorced _____ Other (Please explain) ______________________
Is there any custodial concerns/ parent plan we should be aware of?: ______________________

Mother's Name: ______________	Father's Name: ______________
Place of Employment: ______________	Place of Employment: ______________
Occupation: ______________	Occupation: ______________
Work #: ________ Cell #: ________	Work #: ________ Cell #: ________

MATERNAL AND INFANT HISTORY:

Pregnancy History:	**Infant History:**
Mother's Age at Pregnancy: ______________	Condition of Newborn: ______________
Illness during Pregnancy: ____ No ____ Yes	Birth Weight: ____ lbs. ____ oz.
Please specify: ______________	First Month Complications: ____ No ____ Yes
Any Medications Taken: ______________	Specify: ______________
Duration of Pregnancy: _____ Months Labor: _____ Hours	Discharged from hospital with mother: ____ No ____ Yes
Complications: ______________	Age at discharge from hospital: ______________

DEVELOPMENTAL OR EARLY HISTORY:

This child's birth order: _____ 1st _____ 2nd _____ 3rd _____ 4th _____ 5th Other: ______________
Age when the following developmental steps happened:
Talked (2 words): _______ months; Sat alone: _______ months; Stood alone: _______ months; Walked: _______ months
Toilet Training: Bladder _______ months; Bowel _______ months; Difficulty?: _____ No _____ Yes
Sucked Thumb?: ___ No ___ Yes Is development equal to other children?: ______________
Congenital disease or syndrome diagnosed: _____ No _____ Yes Date of Diagnosis: ______________
Diagnosis: ______________________

MEDICAL HISTORY AND ILLNESS OF STUDENT:

(Check (_) those that are true for this child. Star (*) those that are a present concern)

_____ Allergy	_____ Diabetes	_____ Hyperactivity	**Communicable Diseases:**
_____ Anemia	_____ Drug Allergy	_____ Kidney Disease	_____ Chicken Pox
_____ Asthma	_____ Ear Infections	_____ Meningitis	_____ Cytomegalovirus
_____ Bedwetting	(Tubes in Ears? —)	_____ Nosebleeds – Frequent	_____ Diphtheria
_____ Bladder Infections	_____ Encephalitis	_____ Pneumonia	_____ Infectious Hepatitis
_____ Blood Disorder	_____ Eye Problems	_____ Seizures	_____ Mumps
_____ Bone/Joint Problems	(Wears Glasses?___)	_____ Skin Problems	_____ Polio
_____ Colds – Frequent	_____ Fevers over 104*	_____ Sore throat –Frequent	_____ Red Measles (10 day)
_____ Color Blindness	_____ Headaches	_____ Speech Problems	_____ Rheumatic Fever
_____ Concussion	_____ Hearing Loss	_____ Stomach Aches	_____ Rubella
_____ Convulsions	(Hearing Aids? ___)	_____ Strep Throat- Often	_____ Scarlet Fever
_____ Cystic Fibrosis	_____ Hernia	_____ Thyroid	_____ Tuberculosis
_____ Dental Care	_____ Heart Condition	_____ Tonsillitis	_____ Whooping Cough

Describe severe injuries, including head, surgeries, illness, hospitalizations, etc.:
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Does the child have any physical limitation/ health problems?: ___No ___Yes If yes, please describe: ______________
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OVER

Does this child need special or continuing medical care?: ____No ____Yes If yes, please describe: ______________________________

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CURRENT GENERAL HEALTH STATUS:

Date of last physical exam: ___________ Physician: ______________________ Address: ______________________

Is child taking any medication?: _____ No____ Yes, for: ______________________

Name of medication: ______________________ Dosage: ______________________ Frequency: ______________________

Is medication needed at school?: ____ No ____ Yes

Appetite?: ______________________ Frequently eaten foods: ______________________

High sugar foods eaten?: ________ Seldom ________ Moderately ________ Frequently

Sleep Pattern?: ________ Sound ________ Wakeful ________ Goes to sleep with difficulty Average hours of sleep: ____________

Has child been seen by an eye doctor?: ___ No ___ Yes Name of Practitioner: ______________________

Has child been seen by a speech/ hearing specialist?: ___ No___ Yes Name of Specialist: ______________________

Has child been seen by a dentist/ orthodontist?: ___ No ___ Yes Name of Practitioner: ______________________

SOCIAL BEHAVIOR:

Favorite Activities: ______________________ Home Responsibilities: ______________________

Child behavior/ response to anger: ______________________ Fear/ Conflicts: ______________________

Circle all behaviors that apply to your child: *affectionate, shy, friendly, happy, withdrawn, inactive, curious, hyperactive, impulsive or explosive behavior, cries easily, aggressive, prefers to be alone, easily frustrated.*

Additional comments: ______________________

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Attended a preschool?: _____ No _____Yes If yes, how long?: ______________________

Problems in school: ______________________ Misses school often: _____ No _____ Yes

Has child been seen by a: _____ Psychologist _____ Psychiatrist _____ Counselor Date(s): ______________________

Comments: ______________________

ENVIRONMENTAL FACTORS INFLUENCING EDUCATION PROCESS:

How many times has this child moved in the last two years?: ______________________

Has this child experienced death/ divorce within the immediate family?: ______________________

Agencies working with the family: ______________________

What language did this child first learn?: ______________________ Primary language of the parents?: ______________________

What language is used at home by this child?: ______________________ By the parents and/ or primary caregivers?: ______________________

In your opinion, which language does this child best understand?: ______________________

What are your educational concerns for this child?: ______________________

Family History: (Check (_) the conditions any family members (including parents/ siblings/ grandparents/ aunts/ uncles), have had.

_______ Allergies	_______ Blood Disorders	_______ Hearing Problems	_______ Kidney Problems	_______ TB
_______ Anemia	_______ Diabetes	_______ Heart Problems	_______ Stroke	_______ Vision Problems
_______ Asthma	_______ Epilepsy	_______ High Blood Pressure	_______ Syndromes	_______ Other

If any of the above applies, please specify family member relationship/ condition: ______________________

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SIBLINGS:

Name	Relationship	Age	Health Problems

Parent/ Guardian Signature: ______________________ Date: ______________