Mexico Central Schools
Health History

Name:_____

Date of Birth: _____ Sex: Male Female

Birth and Developmental History:
Birth Weight: _____ Place of Birth:_____
Any complications of pregnancy or delivery? _____
_____
Developmental Milestones:
Sat up _____ Walked _____ First words _____

Medical History: None _____
Does your child have any serious medical problems? (asthma, diabetes, heart or kidney problems, seizures, broken bones, head injuries, migraines):
_____
_____
_____

Surgical History: None _____
Has your child ever had any operations? (tonsils, adenoids, hernia, ear tubes, other): _____
_____

Family History: None _____
Is there any family history (siblings, parents, grandparents) of diabetes, high blood pressure, heart disease, cancer, tuberculosis, asthma? _____
_____
_____

Does your child have any allergies? (foods, medicines, bee stings, environmental): _____
_____

Does your child take any prescription medications (daily or as needed)?
_____
_____

Will your child need any medication during school hours? YES NO
If yes, name of medication: _____
Written permission from the parent/ guardian and your child's health care provider is required. The medication must be delivered to school in the original container.

Does your child wear glasses/ contacts? YES NO
Has your child seen an eye doctor? YES NO
Does your child have a hearing problem? YES NO
If yes, when? _____

Does your child have braces? YES NO
Has your child visited a dentist? YES NO
If yes, when? _____

Do you have any concerns about your child's growth (height or weight)?
_____

Social History:
Number of Adults at home: _____ Number of children at home: _____
Any smokers living in the home: YES NO
Did child attend pre-school? YES NO
Type of dwelling: House_____ Apartment _____Mobile Home _____
Type of Heat: Gas _____ Electric _____ Wood Stove _____
Flooring in bedroom: Carpet ____ Wood ____ Tile ____
Type of Pets: Number of Pets Indoor Outdoor
_____
_____
_____

Emergency Information:
Child's Health Care Provider: _____
Phone: _____
In case your child is ill or injured at school or if there is an urgent situation, please list in order of priority, the adult that should be contacted first:
Name: _____Phone:_____

Name: _____ Phone: _____

Name: _____ Phone: _____