

**Oakdale Joint Unified School District
STUDENT HEALTH HISTORY**

Name _____ School: _____ Date: _____
Last First Middle

Address: _____ City: _____ State: _____

Birth date: _____ City of Birth: _____ State: _____ County: _____

Parent/Guardian Name(s): _____ Home Phone: _____

MEDICAL HISTORY: Necessary information to assure the health and safety of your child will be shared with appropriate staff.

____ tires easily	____ Skin condition	____ Staph/MRSA	____ physical limitations
____ Bladder/Kidney Disease	____ Hepatitis	____ Ear Problems	____ Birth defects
____ Heart Disease	____ Head Injury/concussion	____ Bowel concerns	____ genetic disorder
____ Seizures/Convulsions	____ Autoimmune disorder	____ Diabetes I or 2	____ Asthma
____ Weight concerns	____ Allergic to Bees	____ Speech concerns	____ Fainting
____ Allergic to food(s)	____ Allergic to Latex	____ Other _____	

Other operations, injuries, or hospitalizations and ages of occurrence: _____

Doctor recommendations for any of the above: _____

Child's Doctor's name: _____ Phone: _____

Is the child under a doctor's care now? Yes _____ No _____ If Yes ~ Why? _____

Is child taking medication regularly? Yes _____ No _____ If so, what? _____

Has your child been exposed to tuberculosis? Yes _____ No _____ Had tuberculin skin test? Yes _____ No _____

Has your child ever had a chest X-Ray? Yes _____ No _____

Which of the following have you observed in your child? Please mark all that apply.

____ Plays well with others	____ Angers easily	____ Thumb sucking	____ Cries easily
____ Shares with others	____ Discourages easily	____ Nail biting	____ Hyperactivity
____ Is withdrawn	____ Is distrustful	____ Bed wetting	____ Has fears or worries
____ Stumbles or drops things often	____ Seeks friends	____ Follows instructions	____ Anxiety

What behavior management is most effective with your child? _____

What activity (or activities) does your child enjoy most? _____

BIRTH HISTORY

Birth Weight: _____ Length _____ Problems/Complications _____

Did the mother receive prenatal medical care during her pregnancy? Yes _____ No _____

Was the child full term? Yes _____ No _____ If "No" please explain _____

Was the birth normal? Yes _____ No _____ If "No" please explain _____

Were forceps used? Yes _____ No _____

Was there any breathing difficulty with the infant? Yes _____ No _____ Was oxygen given? Yes _____ No _____

Did the baby go home with the mother Yes _____ No _____ If no please explain _____

How old was the child when he/she began to walk? _____ (Months) Talk? _____ (Months)

EXAMINATIONS

Date of last physical examination: _____

Has child ever been examined by an eye doctor? Yes _____ No _____ If Yes, give date of last exam: _____

Has your child ever been examined by a dentist? Yes _____ No _____ If Yes, give date of last exam: _____

Name of family dentist _____ Phone: _____

IF THERE IS ANY CHANGE IN THE CHILD'S HEALTH, WHICH AFFECTS HIS ABILITY TO TAKE PHYSICAL EDUCATION, OR IF HE/SHE IS PLACED ON A REGULAR MEDICATION, (Educ.Code No. 102020) IT IS THE PARENTS' RESPONSIBILITY TO NOTIFY THE SCHOOL. PLEASE REQUEST FORMS AS NEEDED IF EITHER SITUATION EXISTS OR SHOULD ARISE.

If you have a concern about your child's development and would like a conference with any of the following personnel, please check below and describe your concern.

_____ Nurse _____ School Psychologist _____ Speech and Language Pathologist

I am concerned about my child's development due to: _____

FAMILY MEMBERS (Immediate - Including Parents):

Name	Gender	Birth Date	Birth Place	Relationship to Child	Occupation or Grade

(List additional members on back)

Signature of Parent or Guardian: _____ Date: _____