Calvary Baptist Church Academy
410-768-5306

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Glen Burnie, MD 21060

Health History and Family Factors

Note to the parents:
The purpose of this health and family history form is to identify your child's health risk factors, describe specific health or developmental concerns you may have, assess your child's physical and psychosocial growth and development, determine if there are any family circumstances that may affect your child's learning, and establish what health resources you are currently using.

Child's Name (last, first, middle initial)	Sex (M/F)	Birthdate
Address	Zip Code	Home Phone

Father's Name (and address if different)	Phone (day)	*Who takes care of your child most of the time?* ❑ day care ❑ nursery school/preschool ❑ other early childhood/family program ❑ any services for children with special needs
Mother's Name (and address if different)	Phone (day)	
Physician's name	Phone	
Address		Date of last complete physical exam
Do you have health insurance? ❑Yes ❑No	If yes, carrier	

Family Information

List Family Members

Name	Relationship to child	Highest grade completed	Age	Male or Female

List others living in your home

Name	Relationship
1.	
2.	
3.	

Family Factors

Answering the questions in this section is optional. You are not required to provide this information. Choosing to answer these questions will not affect your child's school entrance but will aid in your child's educational process.

What are some of your family's strengths? ____

Has there been any unusual stress in your family that might affect your child? (examples – new brother or sister, divorce, death of a family member, moving, financial problems.)

____

Is there anything else you would like to discuss which might be interfering with your child's growth and development?

____

Past Health History

Pregnancy	Mother had the following problems during this child's pregnancy: ❑ Rash/German measles ❑ Toxemia/high blood pressure ❑ Diabetes ❑ Anemia ❑ Flu/infection ❑ Urinary tract infection ❑ Vaginal bleeding or infection ❑ Blood transfusions ❑ RH incompatibility ❑ Heart condition ❑ Seizures ❑ Depression ❑ Other, describe: ______________________________ ❑ Mother received x-rays or other treatments during pregnancy. If yes, describe: __________________ ❑ Mother was hospitalized or had surgery. If yes, describe:______________________________ Mother used the following during this pregnancy: If yes, indicate which trimester(s). 0-3 months / 4-6 months / 7-9 months ❑ Aspirin ❑ ❑ ❑ ❑ Alcohol ❑ ❑ ❑ ❑ Laxatives ❑ ❑ ❑ ❑ Cigarettes ❑ ❑ ❑ ❑ Street drugs ❑ ❑ ❑ ❑ Other, describe ❑ ❑ ❑
Birth	Check all boxes that apply to your child. When my child was born: ❑ There were difficulties during labor and/or delivery. ❑ My child had difficulties at birth or shortly after birth. ❑ Actual birth weight _______lbs., _______oz. ❑ My child did not go home from the hospital with his/her mother.
Childhood Illness	My child has had the following diseases: ❑ Meningitis ❑ Mumps ❑ German or three-day measles (Rubella) ❑ Rheumatic fever ❑ Diabetes ❑ "Red" or "hard" measles ❑ Pneumonia ❑ Scarlet fever ❑ High fever (104 for longer than two days) ❑ Strep infections ❑ Chicken pox ❑ Has had other serious illnesses for which he/she was not hospitalized. If so, describe: _____________ ______________________________ ❑ Has been hospitalized. If so, list dates, reason, and treatment given: ______________________________ ______________________________ ❑ Has had one or more serious injuries (broken bones, stitches, strains, sprains). If so, please list: _____ ______________________________
Allergies	My child has had the following problems: ❑ Asthma or hay fever ❑ Eczema or hives ❑ Severe reaction to insect stings ❑ Drug or medication allergy ❑ Food allergy ❑ Reaction to an immunization
Special Health Needs	❑ Has had special tests for health problems ❑ Has been seen by medical specialists ❑ Has had some chronic health problems. Please describe:______________________________ ❑ Takes medication for a health problem
Growth and Development	Were there any delays with your child's development? ❑Yes ❑No Explain: ________________________ ______________________________

Current Health Status (check all that apply to your child)

Skin	❑ Has problems with rashes ❑ Has unexplained lumps or spots ❑ Bruises easily
Head	❑ Has had one or more head injuries. ❑ Has had a period of unconsciousness as a result of injury ❑ Has headaches
Eyes	❑ Has problems with his/her eyes such as squinting, crusty eyelids, mattering ❑ Eyes cross or wander separately ❑ Wears glasses or contact lenses Do you have concerns about your child's vision? ❑Yes ❑No Explain:__________________________

Ear, Nose, and Throat	❑ Has had two or more throat infections in a year ❑ Has frequent nosebleeds ❑ Has swollen glands frequently ❑ Seems to have trouble hearing ❑ Has had ear problems two or more times within a year ❑ Has had earaches or discharge from the ear within the past six months ❑ Has had ventilation (PE) tubes put in his/her ears or other treatment
Respiratory	❑ Has had six to ten colds in a year ❑ Has a severe cough with colds ❑ Has been exposed to tuberculosis ❑ Has shortness of breath, asthma, or wheezing at times ❑ Has trouble getting rid of coughs or colds
Cardio-Vascular	❑ Hands and fingers turn blue ❑ Has heart trouble ❑ I have been told that my child has a heart murmur. ❑ Seems to tire easily
Gastro-Intestinal	❑ Vomits frequently ❑ Has frequent stomachaches ❑ Has diarrhea frequently ❑ Has bloody stools ❑ Has trouble with constipation ❑ Seems to have a problem with foods disagreeing with him/her
Urinary	❑ Is not toilet trained ❑ Has trouble with bedwetting ❑ Has trouble wetting during the day ❑ Has had a kidney or bladder infection
Skeletal	❑ Complains of pains in his/her arm, legs, back, or joints ❑ Limps, toes in or toes out ❑ Has had a broken bone, cast, brace, or corrective shoes
Neuro-Muscular	❑ Loses his/her balance in unusual ways ❑ Has some unexplained movements or jerks ❑ Has had convulsions or seizures ❑ Has a weakness in his/her body ❑ Has staring spells ❑ Seems to fall down more than other children ❑ Is clumsy and awkward
Education	❑ Has your child ever been referred for special testing? By whom____________________________________ Type of testing ________________________________ ❑ Has your child received additional help outside the classroom? Name of provider ______________________________ ❑ Does your child have an IEP (Individual Education Program) or an AIS (Alternative Intervention Strategies)? If yes, explain: ____

List any medications your child takes regularly: ____

____

Describe any physical limitations or restrictions your child has:____

____

Describe any concerns you have about your child: ____

____

____

Are there other children in your family who may have developmental problems? ___________________________

____

Do you have any concerns about your child's behavior? Please explain: _________________________________

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