District 49

Child Find /Preschool Health and Social History

Students Name: _____ Today's date:_____

Students date of birth_____ Child's gender: M/F_____

Form Completed by _____ Relationship to Child_____

Mother's Name: _____ Occupation _____

Mother's relationship to Child: Natural_____ Adopted_____ Foster: _____

Father's Name: _____ Occupation: _____

Father's relationship to Child: Natural_____ Adopted_____ Foster: _____

Prenatal, Labor, Delivery and Birth History:

Mother's age at time of child's birth: _____Length of pregnancy: _____

Baby's birth weight _____ Baby's health condition at birth: _____

Length of baby's hospital stay: _____

Please check and comment on any of the following that applied to the baby:
____ Oxygen used ____ breathing problems ____ feeding problems

Were there concerns about baby's health during the pregnancy, labor, or delivery? _____

If so, please explain: _____

Were any drugs, medications, alcohol, or tobacco used by the mother during pregnancy?

If so, please list and comment: _____

Student's Current Health Status:

How is your child's health now? Excellent _____ Good _____ Fair _____ Poor _____

Explain any health problems or concerns: _____

_____

_____

Does your child have a medical diagnosis? Yes _____ No _____

If so, what is the diagnosis? _____

At what age was the diagnosis determined? _____ What doctor? _____

Is your child on any medications now? Yes _____ No _____

If so, type/frequency_____

List any food/environmental allergies and describe what happens: _____

_____

Has your child ever seen a medical specialist? Yes _____ No _____

If so, please explain_____

Date of last vision test: _____ Where? _____Results: _____

Does your child wear glasses? Yes _____ No _____

Date of last hearing test: _____ Where? _____

Results:_____

Medical History:

Has your child had any of the following? Please check all that apply and comment below:

____Upper respiratory infections	___Anemia/blood disorder
____Ear Infections	___Cardiac/heart concerns
____Asthma	___Seizure
____Stomachache	___Frequent headaches
____food allergies	___Hyperactivity
____bone problems	___Speech concerns
____Bladder/kidney concerns	___Hearing concerns

Comments: _____

Please comment on your child's appetite: _____

What foods does your child have problems eating? _____

How many hours does your child sleep at night? _____ at naptime? _____

Does your child wet the bed? _____ how often? _____

Has your child ever sustained a significant head injury? Yes _____ No_____

If yes, please describe the injury treatment and outcome_____

Please list any surgeries or hospitalizations, including reasons and age at the time: _____

_____

Please list any physical disabilities: _____

Please list any activity restrictions: _____

Family Medical History:

Is there a family history of medical or environmental concerns that might impact your child's ability to learn? _____ Please explain any concerns: _____

Developmental History:

Did your child….

- Smile by 3 months? Yes ____ No ____
- Hold head up by 4 months? Yes ____ No ____
- Roll in both directions by 6 months? Yes ____ No ____
- crawl by 9 months? Yes ____ No ____
- walk by 18 months? Yes ____ No ____
- say words by 15 months? Yes ____ No ____
- Points to and names body parts by 2? Yes ____ No ____
- Use 2-3 word sentences by 3 years of age? Yes ____ No ____
- Was your child toilet trained by 3½ years? Yes ____ No ____
- Were there problems with balance coordination? Yes ____ No ____
- Were there problems with fine motor skills? (feeds self, transfers items from hand to hand, picking item up) Yes _____ No_____
- Do you have other concerns about your child's development? Yes ____ No ____
- Explain: _____

Social History

Whom does your child live with? _____

Has there been a separation or divorce of parents? _____ If so when? _____

If so, is there custody arrangements? _____

Is the separated parent in contact with the child? _____

Are there any siblings? _____

Describe any major changes that have occurred in your family over the past year (moves, health, or new sibling): _____

How is your child handling the change? _____

What are your child's strengths? _____

Does your child make friends easily? _____

Are his/her friends the same age, younger, older? _____

Has your child ever attended a daycare/school type setting? _____

If so, when and for how long? _____

How active is your child? _____

Does your child exhibit any particular fears? _____

Does your child throw fits or tantrums? _____ how often? _____

How long do tantrums last? _____please briefly explain what a tantrum looks like?

_____

Why do you think your child tantrums? _____

_____

Does your child have behaviors that you are concerned about? _____

If so, please describe: _____

_____

Does your child:

____Fall frequently	____Show dare-devil behavior
____Bang head repeatedly	____Rock back and forth
____Prefer to play alone	____Dislikes changes in routine
____Avoid eye contact	____Not respond to his name
____Day dream/ staring spells	____Have difficulty controlling impulses
____Shy/timid	____Overly sensitive to noise

Other comments: _____

_____

Other information

Has your child ever received therapy (Speech, occupational, physical....) from an outside agency or other school? Yes_____ No_____

If so please list the services (type, frequency, who provided the services) _____

_____

Is there anything more you would like to share with us about your child? _____

_____