LOS ANGELES UNIFIED SCHOOL DISTRICT - **PERMANENT HEALTH HISTORY**

Students Name _____ Sex: M ____ F ____ Birth Date _____
LAST FIRST MIDDLE MONTH DAY YEAR

Last School or Children's Center Attended: _____
Name
Location _____
City & State
Present grade _____
SPECIAL CLASS OR SCHOOL _____

Health Care Provider/Physician _____
Date of late physical examination _____
Family Dentist _____
Date of last dental examination _____

FAMILY:	Living with Child(Names)		HEALTH
Father			
Mother			
Stepparent			
Others			
	How Many Older	How Many Younger	HEALTH
Brothers			
Sisters			

Has child ever been hospitalized overnight? Yes____ No ____
Name of hospital _____ _____
City State
Dates in hospital _____ _____
Reason for hospitalization _____

Is child on medication? Yes____ No ____
Name of medicine _____
Amount _____ Frequency _____
Are physical activities limited? Yes____ No____
If yes, reason for limitation: _____

CHILD'S ILLNESS (past or present) please check (✓):

	YES	NO		YES	NO
Chickenpox			Frequent sore throat		
Meningitis			Ear aches/infections		
Mumps			Hearing loss		
Rubella(3-day measles)			Speech problem		
Rubeola(10-day measles)			Eye problem		
Whooping Cough			Wears glasses/Contacts		
Positive TB Skin Test			Heart condition/murmur		
Bronchitis			High Blood Pressure		
Pneumonia			Kidney problem		
Asthma			Sugar Diabetes		
Hives or Eczema			Blood disease		
Drug or Other Allergy			Menstrual problem		
Head Injury			Hernia		
Seizures/Unconscious			Parasites(worms)		

Other serious accidents or illness (describe) _____

(Over - to complete, date and sign)

PERMANENT HEALTH HISTORY (continued)

BIRTH HISTORY

MOTHER'S PREGNANCY:	YES	NO
Infections		
Bleeding		
High Blood Pressure		
Toxemia		
Sugar Diabetes		
Other Complications of Pregnancy		
9-Month Pregnancy		
Type of Delivery		

Child's birth weight_____

child's birth condition (check) good _____ poor _____

If poor, describe: _____

ILLNESS DURING FIRST 2 WEEKS OF LIFE:	YES	NO
Trouble breathing		
Seizures		
Cyanosis(blue color)		
Jaundice(yellow color)		
Feeding problems		
Anemia		
Birth defect		
Required incubator		
Went home with mother		

DEVELOPMENT HISTORY

At what age did your child:

Sit alone _____ Crawl _____

Stand alone _____ Walk _____

Say words _____ Use sentences _____

Toilet train _____ Feed self _____

PLEASE CHECK ( ) DOES YOUR CHILD:

	YES	NO		YES	NO
Enjoy learning			Bite nails		
Like school			Suck thumb		
Like other children			Wet bed		
Eat well			Seem shy		
Drink milk			Fall frequently		
Eat Breakfast			Have temper tantrums		
Sleep well			Seem overactive		
Follow directions					

What time does your child go to bed? _____

Do you have any questions or concerns about your child's health? Please list.

_____

_____

_____

Date _____ Parent/Guardian Signature _____

Date _____ History taken by (Name) _____

Title _____

Name of School _____

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LOS ANGELES UNIFIED SCHOOL DISTRICT
Student Health Services Division