

LOS ANGELES UNIFIED SCHOOL DISTRICT - PERMANENT HEALTH HISTORY

Student's Name _____ Sex: M ____ F ____ Birth Date _____
 LAST FIRST MIDDLE MONTH DAY YEAR

Last School or Children's Center Attended: _____
 Location _____ Name _____
 City & State _____
 Present grade _____
 SPECIAL CLASS OR SCHOOL _____
 Parent 2 _____

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

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

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)		

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: _____

Other serious accidents or illness (describe) _____

**PERMANENT HEALTH HISTORY
 BIRTH HISTORY:**

P.O. 12S-20802-8

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: _____		

DEVELOPMENTAL 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					

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		

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 _____