CONFIDENTIAL

ITHACA CITY SCHOOL DISTRICT
DEVELOPMENTAL - MEDICAL HISTORY

DATE: _____________

CHILD'S NAME: ____ BIRTHDATE: ________________

Male: ____ Female: ____ Birth Place *(City, State)*: ____

PARENT/GUARDIAN NAME: ____

PARENT/GUARDIAN NAME: ____

CHILD LIVES WITH: Father ____ Mother ____ Both ____

Other: ____ Name: ____________________________ Relationship: ______________

Child's Health Insurance

Child Health Plus   Medicaid   Private Insurance   No Insurance

Medical and Dental Information

Doctor ______________________________________ Date of last exam: ______________________

Dentist: _____________________________________ Date of last exam: ______________________

Names and date of birth of other children living in the home:

1. _____________________ DOB:___________ **2.** ____________________ DOB: ____________

3. _____________________ DOB:___________ **4.** ____________________ DOB: ____________

PREVIOUS SCHOOLING

Did your child attend day care or nursery school? Yes ______ No ______

If yes, where?____ How long? ________

Has your child ever attended an Ithaca School? Yes ___ No ___ Name of School: _________________________

Do you have any health concerns related to your child attending school? ________________________________

PROCEDURE FOR EMERGENCY HEALTH CARE

Please fill in the names of two nearby relatives or friends who can be contacted in the event of your child's illness or injury at a time when you are difficult to locate.

1) Name: ________________________________Address: _____________________________

Daytime Phone: _______________

2) Name: ________________________________Address: _____________________________

Daytime Phone: _________________

PLEASE COMPLETE REVERSE SIDE

CONFIDENTIAL **ITHACA CITY SCHOOL DISTRICT** DATE: ______________

DEVELOPMENTAL - MEDICAL HISTORY

Please answer the following questions, and explain all "YES" answers below. Feel free to circle specific information.

1. Has your child had an illness or injury since his/her last physical?...... YES NO
2. Does your child have an ongoing or chronic illness?...... YES NO
3. Has your child ever been hospitalized?...... YES NO
4. Has your child ever had surgery? What and When? ____________________________________ YES NO
5. Does your child take any prescription or non-prescription medications?...... YES NO
   Vitamins? __________ Fluoride? __________ Other: ____________________________________
6. Does your child have any allergies *(for example: pollen, medicine, food)*? ...... YES NO
7. Has your child been stung by a bee or wasp? ...... YES NO
   What was the reaction to the sting? Redness ___ Swelling ___ Breathing difficulties ___
   Does your doctor prescribe emergency medication for stings?...... YES NO
8. Does your child ever get a rash or hives?...... YES NO
9. Has your child had chickenpox?...... YES NO
10. Has your child ever fainted or been dizzy during exercise?...... YES NO
11. Has your child ever had chest pain during or after exercise?...... YES NO
12. Have you been told your child has a heart murmur or heart problems?...... YES NO
13. Have you been told your child has high or low blood pressure?...... YES NO
14. Does your child get frequent or severe nose bleeds?...... YES NO
15. Does your child have problems with his/her bladder or kidneys?...... YES NO
16. Does your child have problems with constipation or diarrhea?...... YES NO
17. Does your child have any skin problems (for example: itching, rashes, acne, warts)?...... YES NO
18. Has your child ever had a head injury or concussion?...... YES NO
19. Does your child ever get headaches?...... YES NO
20. Has your child ever had a seizure?...... YES NO
21. Has your child ever complained of numbness or tingling in the arms, legs, hands or feet?...... YES NO
22. Does your child have asthma or reactive airway disease?...... YES NO
23. Does your child use an asthma medication, inhaler or nebulizer?...... YES NO
24. Does your child cough, wheeze or have trouble breathing during or after activity?...... YES NO
25. Does your child use any special protective or corrective equipment *(for example: back brace, orthotics, hearing aide)?*...... YES NO
26. Has your child had any problems with his/her eyes or vision or wear glasses?...... YES NO
27. Has your child had any problems with hearing or have tubes in his ears?...... YES NO
28. Has your child had dental cavities or problems with teeth or gums?...... YES NO
29. Has your child had any broken bones or problems with pain or swelling in muscles, bones or joints?...... YES NO
30. Do you feel your child is over or under weight?...... YES NO
31. Does your child have special dietary requirements or restrictions?...... YES NO
32. Do you feel your child is stressed out or emotionally upset?...... YES NO
33. ***(For Girls ONLY)*** Has your daughter had her menstrual period?...... YES NO
    If yes, when was her first menstrual period? Age: _____________
    How many days does her period last? __________ When was her last period? ______________
    Do you or she have any concerns about her menstrual periods?...... YES NO
34. Is there family history of any of the following medical problems?...... YES NO
    Please circle all that apply: Diabetes, Heart disease, Sudden cardiac death, Seizure disorder, Emotional disorders, Developmental disorders, High blood pressure, allergies, other: ______________________________________

Do you have any concerns about your child's health? ____

Explain all "YES" answers: ____

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PARENT/GUARDIAN'S SIGNATURE: ____ ***DATE:*** ______________

PLEASE COMPLETE REVERSE SIDE