SAN JUAN UNIFIED SCHOOL DISTRICT **Laurel Ruff Center**
Health Services Department
HEALTH & DEVELOPMENTAL INFORMATION (2013/14 update)

STUDENT: _____ BIRTHDATE: _____ SEX: _____ GRADE: _____

SCHOOL: _____ TEACHER: _____

PREGNANCY/BIRTH: Full term: _____ Premature (# of weeks): _____ Birth weight: _____ Vaginal delivery: _____ C-Section: _____
Month of pregnancy that prenatal care began: _____
Were there any problems during pregnancy? _____
Medication, alcohol, drugs and tobacco used during pregnancy: _____
Were there any problems during/after delivery for mother or baby? _____
DEVELOPMENTAL INFORMATION: Feeding problems? _____ When did baby sit alone? _____
Walk? _____ Talk (1-2 words)? _____ Talk in sentences? _____ Toilet trained? _____

MEDICAL HISTORY: Has your child had a problem in the following areas?

COMMENT ON BACK OF FORM IF "YES" - WHEN, TREATMENT PROVIDED, ETC.

	Yes	No		Yes	No
Physical Disability	☐	☐	Fainting Spells/Dizziness	☐	☐
Diabetes	☐	☐	Asthma/Breathing Problems	☐	☐
Stomach/Intestinal	☐	☐	Headaches	☐	☐
Heart Problems	☐	☐	Eye/Vision Problems	☐	☐
Anemia/Blood Disorders	☐	☐	Ear/Hearing Problems	☐	☐
Tumors	☐	☐	Frequent Colds	☐	☐
Leukemia/Cancer	☐	☐	Nosebleeds	☐	☐
Hepatitis/CMV	☐	☐	Frequent Urination/Bedwetting	☐	☐
Encephalitis/Meningitis	☐	☐	Skin Problems	☐	☐
Convulsions or Seizures	☐	☐	Eating Problems/Appetite	☐	☐
Emotional Disturbance	☐	☐	Family History of Learning Problems	☐	☐
Psychiatric Care	☐	☐	Genetic Disorder	☐	☐
Surgery	☐	☐	Females: Onset of menstruation _____		
Serious Illness, High Fever	☐	☐	Problem _____		
Accidents	☐	☐			

Allergies: _____
How does this allergy show? _____
Is emergency medication required for this allergy (if so, what?) _____
What medication does your child take on a regular basis? _____

Current Height: _____ Weight: _____
How would you describe the child's general health? Good _____ Poor _____ Comment: _____
_____

Summary of current health conditions: _____
_____

Is there any additional information which would be of help in promoting your child's welfare and enhancing his/her education? _____
_____

PHYSICIAN'S NAME: _____ Date/reason for last visit: _____
DENTIST'S NAME: _____ Date/reason for last visit: _____

EYE DOCTOR: _____ Date/reason for last visit: _____

Describe eye problem: _____ Wear glasses now? _____ Glasses first prescribed: _____

DATE: _____ SIGNATURE: _____ RELATIONSHIP: _____