

**DEVELOPMENTAL AND HEALTH HISTORY INFORMATION  
WEST DELAWARE COUNTY COMMUNITY SCHOOL**

STUDENT: \_\_\_\_\_

GRADE: \_\_\_\_\_ (Last) (First) (M) (F)  
BIRTHDATE: \_\_\_\_\_

HOME ADDRESS: \_\_\_\_\_

FATHER'S NAME: \_\_\_\_\_ BIRTHDATE: \_\_\_\_\_

ADDRESS: (If different than students) \_\_\_\_\_

HOME PHONE: \_\_\_\_\_ CELLPHONE: \_\_\_\_\_

MOTHER'S NAME: \_\_\_\_\_ BIRTHDATE: \_\_\_\_\_

ADDRESS: (If different than students) \_\_\_\_\_

HOME PHONE: \_\_\_\_\_ CELLPHONE: \_\_\_\_\_

STUDENT LIVES WITH: \_\_\_\_\_ NATURAL FATHER \_\_\_\_\_ NATURAL MOTHER \_\_\_\_\_ STEPFATHER  
\_\_\_\_\_ STEPMOTHER \_\_\_\_\_ FOSTER PARENTS \_\_\_\_\_ GRANDPARENTS \_\_\_\_\_ AUNT/UNCLE  
OTHER \_\_\_\_\_

NUMBER OF BROTHERS: \_\_\_\_\_ AGES: \_\_\_\_\_

NUMBER OF SISTERS: \_\_\_\_\_ AGES: \_\_\_\_\_

FAMILY PHYSICIAN: \_\_\_\_\_

FAMILY DENTIST: \_\_\_\_\_

Yes No IS YOUR CHILD COVERED BY HEALTH INSURANCE?

PLEASE FILL OUT INFORMATION ON PRENATAL /BIRTH CARE:

Received prenatal care Yes No Medications taken during pregnancy: \_\_\_\_\_

Problems with pregnancy; bleeding, excessive swelling, weight loss, high blood pressure, infection, sickness, other Yes No

Problems with labor/delivery Yes No Baby arrived on time Yes No

Length of labor: \_\_\_\_\_ Birth weight: \_\_\_\_\_

Type of delivery: Normal Breech C-section Instruments

Please explain any of the above that is needed: \_\_\_\_\_

PLEASE FILL OUT INFORMATION ON YOUR CHILD'S DEVELOPMENT:

List ages as closely as you can remember, when your child:

Sat alone \_\_\_\_\_ Walked alone \_\_\_\_\_ Said first word \_\_\_\_\_

Y N Child's speech is understandable to others?

Y N Child has been treated for foot, leg, hip or other bone development problems?

If so, what AGE \_\_\_\_\_ FORM OF TREATMENT \_\_\_\_\_

OVER

Y N Is child toilet trained? Day Wetting? Y N Night Wetting? Y N

Y N Child has problem with bowel control? Explain: \_\_\_\_\_

**DO YOU THINK YOUR CHILD IS DEVELOPING AS MOST CHILDREN HIS/HER AGE?**

Physically? Y N Mentally? Y N Emotionally? Y N

Please comment: \_\_\_\_\_

**PLEASE FILL OUT INFORMATION ON YOUR CHILD'S HEALTH HISTORY:**

Y N Any Hospitalizations? Age and reason: \_\_\_\_\_

Y N Serious accidents/injuries? Age and reason: \_\_\_\_\_

Childhood diseases? (Examples like chicken pox, mumps, scarlet fever, RSV) \_\_\_\_\_

Y N Appetite problems? \_\_\_\_\_

Y N Frequent ear infections?  
Surgery/tubes: \_\_\_\_\_ Date: \_\_\_\_\_

Y N Glasses? Date: \_\_\_\_\_

Y N Convulsions (seizures)? Age of onset: \_\_\_\_\_

Describe seizure and date of last seizure: \_\_\_\_\_

Y N Lead screening? This will be completed on your child's physical form but if a physical is not completed then the information MUST be filled in here. Date/Results: \_\_\_\_\_ Treatment: \_\_\_\_\_

Y N Child has allergies? Please circle type of allergy: Asthma Hayfever Insect bites/Stings Dust/Mold

Y N Food allergies? Describe: \_\_\_\_\_

Y N Medication allergies? Describe: \_\_\_\_\_

**ARE EMERGENCY PROCEDURES REQUIRED FOR ANY OF THE ABOVE CONDITIONS?**

(Such as an EpiPen for severe allergies to bees/insects)

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_