# West Delaware County Community School District

## Health and Developmental History

**Student**: _____ **Grade**: _____

**Birthdate**: _____ **Male Female**

**Home Address**: _____

**Mother's name**:_____ **Home phone**: _____ **Cell**: _____

**Address**: (if different from student's) _____

**Father's** name: _____**Home phone**: _____ **Cell**: _____

**Address**: (if different from student's) _____

**Student lives with**: ___ Natural Father ___ Natural Mother ___Stepmother ___Stepfather ___Foster parents
___ Grandparents ___Aunt/Uncle ___ Other: _____

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### Medical/Developmental Information

**Physician**: _____ **Phone number**: _____

**Dentist**: _____ **Phone number**: _____

**Insurance provider**: _____

**Current medications** (both at school and at home): _____

_____

**Allergies to medications, foods, pollens, etc**.: _____

**Expected reaction to each allergen**: _____

**Medical Diagnoses/ Health Problems**: (circle all that apply)

Asthma ADD/ADHD Seizures Diabetes Bleeding Disorder Heart Problems Depression

Anxiety Migraines Bowel Problems Bed Wetting/Accidents Dietary Needs

Other: _____

**Please list all other special accommodations for before, during, or after school, or accommodations and medications for emergency treatment** (such as epi-pens, inhaler, etc.): _____

_____

**Does your child wear glasses?** YES NO **Does your child wear contacts?** YES NO
**Does your child have hearing problems?** YES NO **Does your child have tubes in their ears?** YES NO

**Has your child been hospitalized or had serious accidents/injuries?** YES NO
Age/Reason: _____

**Is your child:**
Developmentally delayed? YES NO Speech understandable to others? YES NO
Been treated for foot/leg, hip, or bone problems? YES NO Toilet trained? YES NO
Additional information: _____

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