TMCSEA
Tazewell Mason Counties Special Education Association
300 Cedar Street Pekin IL, 61554-2576
Ph. 309/347-5164 - Fax 309/346-0440

Student Health History

Student name:_____ DOB_____

Address: _____ Phone:_____

School:_____ Place in Family____ of____children

Pre-Natal

Age of mother at time of pregnancy _____ Was pre-natal care established? □YES □NO
Where?_____ At how many weeks did you deliver?_____
During this pregnancy did you have (check all that apply):

□Anemia	□ Swollen ankles	□ Flu	□ Chronic illness
□ Diabetes	□ Epilepsy	□ High blood pressure	□ Heart disease
□ Injury	□ Bleeding	□ Toxemia	□ Measles
□ German Measles	□ Excessive Weight gain or loss		□ Medication during pregnancy

Any other concerns?_____

Birth

Unusual delivery? □Yes □No Caesarean? □Yes □No Complication?_____

What did baby weight?_____ Breast Fed?_□Yes □No Where was the baby Born?_____

Did you take baby with you from Hospital? □Yes □No If not how long after?_____

Any concerns during the first 12 months? □Yes □No If yes, explain_____

_____

_____

Developmental (*indicate age)*

Age held up head____ Crawled_____ Said sentence_____ Feeds self_____
Bowel trained_____ Dry during day_____ Dry at night_____Dressed alone_____
Eats Well? _____ Feeding problems?_____ Right/ Left handed

Speech Clear □Yes □No Affectionate baby □Yes □No

Was baby normally active? □Yes □No Wanted to be left alone? □Yes □No

Check all that apply

□ Temper tantrums	□ Hyperactive	□ Breath holding
Well Coordinated? □Yes □No	Good with hands? □Yes □No	Blank Spells □Yes □No
Impulsive □Yes □No	Unusual fears? □Yes □No	Sleep Problems □Yes □No
Head banging? □Yes □No	Early Intervention services □Yes □No_____	

Other behaviors observed_____

_____

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Medical (*if yes indicate when)*

Measles □Yes □No_____ German measles □Yes □No_____ Mumps □Yes □No_____

Chicken pox □Yes □No_____ Strep throat □Yes □No_____ Scarlet fever □Yes □No_____

Meningitis □Yes □No_____ Encephalitis □Yes □No_____ Seizures □Yes □No_____

High fever □Yes □No_____ Allergies □Yes □No_____

Injury or blow to head □Yes □No_____ Repeated ear infection □Yes □No

Eye problems □Yes □No _____ Diabetes □Yes □No _____ Heart Disease □Yes □No____

Injury □Yes □No _____ Fractures □Yes □No_____ Other Illness □Yes □No____

Surgery □Yes □No_____

Overnight in hospital □Yes □No_____

Asthma □Yes □No_____ ADHD □Yes □No_____

Other significant health history not listed_____

_____

_____

_____

Taking medication for anything in the past or now? □Yes □No _____

_____

_____

Any other information you wish to tell the nurse_____

_____

_____

_____