HEALTH HISTORY
Colfax Elementary School

NAME_____ BIRTHDATE _____ SEX _____ GRADE _____

BIRTH & INFANCY Full Term . Premature _____ Birth weight _____

Delivery Were there any problems? _____

Did baby go home with mother? _____

Developmental: Feeding problems? . _____ When did child sit alone? _____

Walk _____ Talk _____ Become Toilet trained _____

MEDICAL HISTORY

Has your child been subject to:	Never	More than 1 year ago	Within Past year
Cerebral Palsy			
Diabetes			
Epilepsy			
Heart Disease			
Rheumatic Fever			
Chickenpox			
Whooping Cough			
Scarlet Fever			
Hepatitis			
Encephalitis			
Convulsions			

Has your child been subject to:	Never	More than 1 year ago	Within Past year
Dizziness			
Fainting Spells			
Tire Easily			
Headaches			
Eye Problems			
Ear Problems			
Frequent Colds			
Nosebleeds			
Frequent Urination			
Other:			
Other:			

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? _____

Has your child been hospitalized or treated for a serious illness or accident? Is so, when, what, and where: _____

_____

_____

Operations: _____

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

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

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

Were glasses prescribed? _____

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

_____

DATE: _____ SIGNATURE: _____