



## School Health Questionnaire

7. Where there any complications during pregnancy and/or labor / delivery? \_\_\_\_\_ Yes \_\_\_\_\_ No  
 If Yes, explain \_\_\_\_\_
8. Is your child under medical treatment at present? \_\_\_\_\_ Yes \_\_\_\_\_ No
9. Has your child had any serious accidents? \_\_\_\_\_ Yes \_\_\_\_\_ No  
 If Yes, explain \_\_\_\_\_
10. Describe briefly any traumatic events that your child has experienced (for example: death of close relative, divorce, family crisis, etc.)

### 11 List Specific Allergies and Treatment

### Health History

Check below any of the following illnesses/conditions your child has had. Indicate approximate date of onset (first symptoms). Explain below, including treatment and health professionals involved.

Check		Check		Check	
	Arthritis		Ear Infections		Mono
	Asthma		Eczema		Mumps
	Bladder Infection		Headaches/Migraines		Pneumonia
	Blood Disorder		Heart Murmur		Polio
	Blood Pressure-High		Heart Problems		Rheumatic Fever
	Blood Pressure-Low		Hepatitis		Rubella (German Measles)
	Broken Bones		High Fever		Scarlet Fever
	Bronchitis		Hives		Seizures
	Cancer		Influenza		Thyroid Disease
	Chickenpox		Kidney disease		Tonsillitis
	Concussion		Malaria		Tuberculosis
	Diabetes		Measles		Typhoid
	Diphtheria		Meningitis		Whooping Cough
	Other:		Other:		Other

Please Explain: