South O'Brien Community School Health History

Child's Name _____
Last First Middle

Birthdate: _____ Sex _____

Father's Name _____

Mother's Name _____

The child lives with (circle all that apply)

Both biological parents	Grandparents	Foster parents
Biological mother	Stepfather	Other _____
Biological father	Stepmother	

Please circle all areas of concern:

Speech	Eats too much	Eats too little
Stomach ache	Bowels	Bladder
Bedwetting	Asthma	Headaches
Hearing	Sleep	Tires easily
Daydreams	Inattentive	Nose Bleeds
Easily upset	Temper tantrums	Frequent crying
Nail biting	Sucks finger/thumb	

Comments _____

_____

Allergies: _____

Does your child have an epi-pen? _____

Medications: _____

Are there any significant family situations, such as separation, divorce, remarriage, illness, new baby, move, etc., you feel we should know about so we may better understand your child?_____

_____

_____

_____