

## Child/Family History

Child's Full Name \_\_\_\_\_ SSN \_\_\_\_\_ DOB \_\_\_\_\_

Address \_\_\_\_\_ Home Phone \_\_\_\_\_ Cell \_\_\_\_\_

Sex- Male/Female Race- \_\_\_\_\_ Child's City of Birth \_\_\_\_\_ Mother's Maiden Name \_\_\_\_\_

### EMERGENCY CONTACTS

\*\*STUDENT RESIDES WITH (Please Circle)      -Mother   -Father   -Both Parents   -Legal Guardian

\*\*If divorced or separated, parent with Legal Custody: \_\_\_\_\_  
(Most Recent Court Paperwork Must Be On File)

Mother/Legal Guardian

Father/Legal Guardian

\_\_\_\_\_  
 Last Name                                      First Name                                      Last Name                                      First Name

**\*\*\* Confidential information you do not wish to include on this report may be discussed privately during the exit conference.**

### Family History

	<u>Yes</u>	<u>No</u>
Single Parent	_____	_____
Divorced Parent	_____	_____
Step Parent in Household	_____	_____
Mother Works	_____	_____
Father Works	_____	_____

Birth Order of Child \_\_\_\_\_  
 Siblings (Step) Living in the Home-  
     Name                                      Age  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

Number of persons living in the household \_\_\_\_\_  
 Has child attended:      Yes      No      Dates  
 Child Development Center: \_\_\_\_\_  
 Headstart: \_\_\_\_\_  
 Pre-School Program: \_\_\_\_\_

### Child's Medical History

Was the child premature? \_\_\_\_\_  
 Were there complications? Yes \_\_\_\_\_ No \_\_\_\_\_  
 If yes, please describe \_\_\_\_\_  
 \_\_\_\_\_  
 Were there complications during or immediately following the  
 child's birth? Yes \_\_\_\_\_ No \_\_\_\_\_ If yes, please describe  
 \_\_\_\_\_  
 \_\_\_\_\_  
 Medical Insurance Provider and Identification Number: \_\_\_\_\_

### Has the child had any of the following illnesses?

	YES	NO
Measles		
Rubella- 3 day measles		
Chickenpox		
Whooping Cough		
Mumps		
Scarlet Fever		
Rheumatic Fever		
Skin Infections		
Meningitis		
Seizures		
Frequent Colds/Sore Throats		
Kidney/Bladder Infection		
Broken Bones		
Accidents or injuries		
Poisoning		
Hospitalizations		
Heart Conditions		
Other (please list)		

Date of previous medical evaluations: \_\_\_\_\_  
 Vision: \_\_\_\_\_  
 Hearing: \_\_\_\_\_  
 Language/Speech: \_\_\_\_\_  
 Dental: \_\_\_\_\_  
 Previous psychological evaluations: \_\_\_\_\_  
 Medication received on regular basis: \_\_\_\_\_  
 Allergies: \_\_\_\_\_

Districts are required to identify students whose parents or legal guardians have been an active member of the Armed Forces or National Guard at any time throughout the current year. **Please check ✓ the option below that best describes the student's Military Student identifier status at any point during the school year.**

- \_\_\_\_\_ \* - **Not Applicable** (Not a Military Student)
- \_\_\_\_\_ **A - Active Duty**- Student is a dependent of a member of the Active Duty Forces (Army, Navy, Air Force, Marines Corp or Coast Guard)
- \_\_\_\_\_ **B - National Guard**- Student is a dependent of a member of the National Guard (Army or Air)

