LOS ANGELES UNIFIED SCHOOL DISTRICT - **PERMANENT HEALTH HISTORY**

Students Name ______________________ Sex: M ____ F ____ Birth Date ______________
LAST FIRST MIDDLE MONTH DAY YEAR

Last School or Children's Center Attended: ______________________
Name
Location ______________________
City & State
Present grade ____________
SPECIAL CLASS OR SCHOOL ______________________

FAMILY:	Living with Child(Names)		HEALTH
Father			
Mother			
Stepparent			
Others			
	How Many Older	How Many Younger	HEALTH
Brothers			
Sisters			

Has child ever been hospitalized overnight? Yes ____ No ____
Name of hospital ________ ______________________
City State
Dates in hospital ________ ______________________
Reason for hospitalization ______________________

Is child on medication? Yes ____ No ____
Name of medicine ______________________
Amount ______________ Frequency ______________
Are physical activities limited? Yes ____ No ____
If yes, reason for limitation: ______________________

Health Care Provider/Physician ______________________
Date of late physical examination ______________________
Family Dentist ______________________
Date of last dental examination ______________________

CHILD'S ILLNESS (past or present) please check (✓):

	YES	NO		YES	NO
Chickenpox			Frequent sore throat		
Meningitis			Ear aches/infections		
Mumps			Hearing loss		
Rubella(3-day measles)			Speech problem		
Rubeola(10-day measles)			Eye problem		
Whooping Cough			Wears glasses/Contacts		
Positive TB Skin Test			Heart condition/murmur		
Bronchitis			High Blood Pressure		
Pneumonia			Kidney problem		
Asthma			Sugar Diabetes		
Hives or Eczema			Blood disease		
Drug or Other Allergy			Menstrual problem		
Head Injury			Hernia		
Seizures/Unconscious			Parasites(worms)		

Other serious accidents or illness (describe) ______________________

(Over - to complete, date and sign)

PERMANENT HEALTH HISTORY (continued)

P.o.12s-20802-8

BIRTH HISTORY

MOTHER'S PREGNANCY:	YES	NO
Infections		
Bleeding		
High Blood Pressure		
Toxemia		
Sugar Diabetes		
Other Complications of Pregnancy		
9-Month Pregnancy		
Type of Delivery		

Child's birth weight ________
child's birth condition (check) good ______ poor ______
If poor, describe: ______________________

ILLNESS DURING FIRST 2 WEEKS OF LIFE:	YES	NO
Trouble breathing		
Seizures		
Cyanosis(blue color)		
Jaundice(yellow color)		
Feeding problems		
Anemia		
Birth defect		
Required incubator		
Went home with mother		

DEVELOPMENT HISTORY

At what age did your child:
Sit alone ____________ Crawl ____________
Stand alone ____________ Walk ____________
Say words ____________ Use sentences ____________
Toilet train ____________ Feed self ____________

PLEASE CHECK ( ) DOES YOUR CHILD:

	YES	NO		YES	NO
Enjoy learning			Bite nails		
Like school			Suck thumb		
Like other children			Wet bed		
Eat well			Seem shy		
Drink milk			Fall frequently		
Eat Breakfast			Have temper tantrums		
Sleep well			Seem overactive		
Follow directions					

What time does your child go to bed? ______________________
Do you have any questions or concerns about your child's health? Please list.

____

Date ____________ Parent/Guardian Signature ______________________
Date ____________ History taken by (Name) ______________________
Title ______________________
Name of School ______________________

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LOS ANGELES UNIFIED SCHOOL DISTRICT
Student Health Services Division