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 _____

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

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 _____ Reasons for hospitalization _____

_ Is child on medication? Ye ☐ N ☐
Name of medicine _____
Amount _____ Frequency _____
Are physical activities limited? Yes ☐ No ☐
If yes, reason for limitation: _____

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	☐	☐	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) _____

BIRTH HISTORY

MOTHER'S PREGNANCY:	YES	NO
Infections	☐	☐
Bleeding	☐	☐
High Blood Pressure	☐	☐
Toxemia	☐	☐
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 UNFIED SCHOOL DISTRICT
Student Health and Human Services Division