



POMPERAUG REGIONAL SCHOOL DISTRICT 15

Serving the Communities of Middlebury and Southbury, Connecticut

HEALTH AND DEVELOPMENT QUESTIONNAIRE

Thank you for taking the time to complete this questionnaire. The following questions have been developed so that we are aware of any special circumstances that may affect your child's progress in school. Please be assured that the information contained in this questionnaire will be treated sensitively.

Student's Name: _____ Date of Birth: _____

Today's Date: _____

Name of person completing form and relationship to child: _____

BIRTH HISTORY

Prenatal

During pregnancy did the mother have any of the following conditions?

- () High Blood Pressure () Pneumonia () Toxemia
- () German Measles () Bleeding () Other _____

Comments: _____

During pregnancy did the mother:

- () have any accidents? () have any x-rays () require any bed rest?

Comments: _____

Were any medications used during pregnancy? _____ If yes, please indicate kinds and amount _____

Was there any prenatal exposure to alcohol or drugs? _____

Birth

Was the infant () Full Term? () Premature? _____

Was the delivery: () Natural? () Induced? () Cesarean?

() Breech? () Multiple Birth?

What was the length of delivery? _____

Was the umbilical cord wrapped around the baby's neck? _____

What was the child's birth weight? _____

What were the infant and mother's general condition at birth? _____

What was the length of stay in the hospital? _____

Postnatal

As an infant were there any:

() feeding problems? () eating problems () sleeping problems?

Comments: _____

Was he/she an easily contented infant? _____

Did he/she enjoy being held, cuddled, etc.? _____

DEVELOPMENTAL HISTORY

If you are unable to recall specific ages, please indicate whether the following developmental milestones were met *early, late, or within normal limits.*

Motor

Age at which child:

held head up _____ first rolled over _____ sat unsupported _____

began creeping/crawling _____ began standing _____ began walking _____

Language

Did your child dribble or drool a lot as a baby? _____

Age at which child:

first started babbling _____ began to use sounds to represent words like 'ba' for bottle _____

used short sentences _____

How many words do your child's sentences typically contain? _____

How is your child's articulation? _____

Self-Help

Age at which child:

drank from a cup _____ began feeding self _____ was toilet trained _____

Can your child:

() wash hands alone? () bathe alone? () dress him/herself?

() button buttons? () work zippers? () tie shoes?

Was there ever any regression or loss of the above developmental skills? _____

HEALTH HISTORY

Does/did your child have any of the following? If so, how is/was it treated?

() problems with vision _____

() frequent headaches _____

() problems with hearing _____

() history of ear infections _____

() frequent colds _____

() frequent high fevers _____

() frequent strep throats _____

() frequent stomach aches or vomiting _____

Does your child have any of the following health conditions?

() Allergies (food, environmental, insect, etc.) _____

() Attention Deficit Disorder or Attention Problems _____

() Asthma _____

() Diabetes _____

() Anemia _____

() Heart disorder _____

() Seizure disorder _____

() Other _____

Does your child have a condition that requires medication? If so, what is the type and dosage? _____

Has your child ever had any of the following childhood diseases?

- Chicken Pox Measles German Measles Mumps
 Whooping Cough Diphtheria Scarlet Fever Pneumonia
 Fifth Disease Other _____

Comments: _____

Has your child ever had any of the following serious illnesses?

- Encephalitis Meningitis Toxic conditions
 Rheumatic Fever Lead Poisoning Other _____

Comments: _____

Has your child ever:

- fainted or lost consciousness had a seizure or convulsion?
 had a serious accident (fall, automobile, etc.) that resulted in a injury?
 had any special tests (EEG, EKG, X-rays, Spinal Tap, Neurological, Laboratory work, etc.)?
 been hospitalized? had surgery?

Comments: _____

Is there a family history of any of the following?

	Maternal	Paternal
Learning Disabilities	<input type="checkbox"/>	<input type="checkbox"/>
Attention Deficit Disorder	<input type="checkbox"/>	<input type="checkbox"/>
Mental Illness	<input type="checkbox"/>	<input type="checkbox"/>
Epilepsy	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>
Other _____	<input type="checkbox"/>	<input type="checkbox"/>

Comments: _____

Please add any other information that you think might be helpful in getting to know your child _____

Would you like to speak to the School Nurse before your child begins school? _____
