POMPERAUG REGIONAL SCHOOL DISTRICT 15

Serving the Communities of Middlebury and Southbury, Connecticut

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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	( )	( )
Attention Deficit Disorder	( )	( )
Mental Illness	( )	( )
Epilepsy	( )	( )
Diabetes	( )	( )
Other_____	( )	( )

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?_____
_____