Health and Development Information
Pleasant Ridge Union School District

Child's Name _____ School _____

Date of Birth _____ Male/Female *(circle one)* Phone _____

Parent's or Guardian's Names_____

Participation in Infant or Preschool Early Intervention Programs (special education or special needs)

☐No ☐Yes If yes, identify the program_____

Participation in preschool (non-special education/special needs) ☐No ☐Yes

If yes, list program_____

Please list any other programs or classes in which your child participated _____

_____

Does your child have difficulties or need extra help in any of the following areas? Check all that apply.

Large (gross) motor	☐kicking, running, jumping, catching a ball, skipping
Small (fine) motor	☐using a pencil, cutting, tying shoelaces, dressing self, putting things together
Focusing	☐attention span, following directions, remembering routine
Social Interactions	☐communication, making friends, anger/impulse control, taking turns/sharing
Transitions	☐accepting changes in schedule, accepting adults other than parents, communication of needs or questions

Age of mother during pregnancy_____ Full time pregnancy?_____

Any problems during pregnancy? ☐No ☐Yes If yes, explain _____

Any problems at birth? ☐No ☐Yes If yes, explain _____

Any problems at infancy (feeding, illness, injury)? ☐No ☐Yes If yes, explain_____

Does your child exhibit any of the following:

Hearing problems ☐No ☐Yes If yes, explain _____

Speech problems ☐No ☐Yes If yes, explain _____

Physical limitations ☐No ☐Yes If yes, explain _____

Please indicate by a check (✓) if there are any concerns as to age when your child was able to do the following:

Sat up by self_____ Walked_____ Spoke in 3-word phrases_____ Socialized w/ children his/her age_____

Please list any problems with developmental delay, physical condition, vision, hearing, language delay,

or illness (not covered above): _____

_____

Please describe concerns and follow-up programs: _____

_____

Any other comments: _____

_____

Please list any past childhood diseases (i.e. chicken pox, measles, pertussis, etc.) _____

Please list any past health examinations or concerns: _____

Is your child currently under treatment/therapy or been seen by a health care provider in the last 3 months?

☐No ☐Yes If yes, explain: _____

Check any ***present*** concerns about ☐attention span; ☐coordination (large or small muscle); ☐behavioral or social skills; ☐overall health (eating, sleeping, weight, height, dental, energy, emotional)

If checked, please explain: _____

_____

Does your child have any physical limitations that would make it unwise or difficult to participate in regular or physical activity (i.e. team sports, vigorous recess activity)? If yes, explain: _____

_____

Please check no or yes to the health conditions (past or present) listed below. If yes, please explain.

	No	**Yes**	
Allergies	☐	☐	Type: _____ Medication? _____
Asthma	☐	☐	Medication or restrictions? _____
Ear infections	☐	☐	Frequent?_____ Tubes? _____ Medication?_____
Hearing problems	☐	☐	Evaluations or treatment? _____
Visual or eye problems	☐	☐	Glasses? _____ Last exam date? _____
Diabetes	☐	☐	Treatment? _____
Epilepsy or seizures	☐	☐	Medications or treatment? _____
Handicap/disabling conditions	☐	☐	Medication/assistance device or therapy? _____
Emotional concerns	☐	☐	Medication or treatment? _____
Stomach or bowel concerns	☐	☐	Medication or treatment? _____
Pneumonia, bronchitis, strep	☐	☐	Frequency? _____ Medication or treatment_____
TB contact or infection	☐	☐	Treatment: _____
ADD/ADHD	☐	☐	Medication or therapy? _____
Hospitalizations (surgeries, illness, trauma)	☐	☐	Dates and reasons: _____
Is your child on **any** medications? (please include vitamins or herbal preparations)	☐	☐	List medication and doctor: _____

If your child must have medication while at school, a release form must be completed prior to administration.

Parent Signature _____ Date _____

Print Name _____