AUBURN UNION SCHOOL DISTRICT
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AUBURN, CA 95603
PHONE 530.885.7242
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PRESCHOOL HEALTH HISTORY FORM

Date: _____

Child's name: _____ Date of Birth: _____
Last First Middle

Parent or Guardian's Name: _____ Home Phone: _____

Address: _____ Work Phone: _____
Street City ZIP

Cell Phone: _____

Mailing Address: _____
Street City ZIP

Email: _____

Parent or Guardian's Name: _____ Home Phone: _____

Address: _____ Work Phone: _____
Street City ZIP

Cell Phone: _____

Mailing Address: _____
Street City ZIP

Email: _____

CHILD'S ETHNICITY/RACE

What is your child's ethnicity? (Please check one): ❒ Hispanic or Latino ❒ Not Hispanic or Latino
What is your child's race (Please check up to five racial categories)

The above part of the question is about ethnicity, not race. No matter what you selected above, please continue to answer the following by marking one or more boxes to indicate what you consider your race to be.

❒ American Indian or Alaskan Native	❒ Laotian	❒ Samoan
❒ Chinese	❒ Cambodian	❒ Tahitian
❒ Japanese	❒ Hmong	❒ Other Pacific Islander
❒ Korean	❒ Other Asian	❒ Filipino/Filipino American
❒ Vietnamese	❒ Hawaiian	❒ African American or Black
❒ Asian Indian	❒ Guamanian	❒ White

Child lives with: ❒ Parent ❒ Guardian ❒ Step-Parent ❒ Foster Parent ❒ Other: _____

If living with Foster Parent, indicate who has educational rights: _____

If living with Guardian or Conservator, provide court date: _____

Was the child adopted? ❒ Yes ❒ No Date of Adoption: _____

Childs's primary language: _____ Other languages spoken in home _____

Describe your child's strengths and interests:

_____

_____

_____

_____

What concerns you most about your child?

_____

_____

_____

_____

_____

FAMILY INFORMATION

Parent:

Relationship to Child: _____ Occupation: _____ Age: _____

❒ Living with child ❒ Divorced/Separated ❒ Deceased ❒ Married ❒ Single ❒ Other: _____

Describe any learning, emotional, or medical difficulties:

_____

_____

_____

_____

_____

Parent:
Relationship to Child: _____ Occupation: _____ Age: _____
❒ Living with child ❒ Divorced/Separated ❒ Deceased ❒ Married ❒ Single ❒ Other: _____
Describe any learning, emotional, or medical difficulties:

Other members of the household:

Name	Relationship to Child	Age

Are there other family members with learning, emotional, or medical difficulties: ❒ Yes ❒ No
If yes, please describe:

BEHAVIOR AND EMOTIONAL ISSUES
How is your child's interaction with peers? ❒ Poor ❒ Fair ❒ Good ❒ Excellent
Describe any difficulties:

How is your child's interaction with adults? ❒ Poor ❒ Fair ❒ Good ❒ Excellent

Describe any difficulties:

Is your child's behavior appropriate at home? ❒ Yes ❒ No ❒ Don't Know

Please describe:

MEDICAL INFORMATION

Mother's Pregnancies:

Number of Pregnancies: _____ Were there any stillbirths or miscarriages? ❒ Yes ❒ No

Mother's children:

Name	Birth Date	Child's Health

Pregnancy history for this child:

Did mother have any illness, accidents or stress during pregnancy? ❒ Yes ❒ No

If yes, please describe:

Did mother have regular medical examinations? ❒ Yes ❒ No At what month was the first exam? _____

Check any of the following that apply to mother during this pregnancy:

❒ Took prescribed medications ❒ Used drugs

❒ Took over-the-counter medications ❒ Drank alcohol

Please list medications:

_____

_____

_____

_____

_____

Birth history:

Child born at: ❒ Home ❒ Hospital Physician present? ❒ Yes ❒ No

Type of delivery:

Describe any difficulties during labor:

_____

_____

_____

_____

Check if any of the following occurred:

❒ Premature Birth ❒ Multiple Birth ❒ Stayed in Newborn Intensive Care

❒ Fetal Distress ❒ Drug Withdrawal ❒ Seizures

❒ Required Oxygen or Respirator

Length of stay in the hospital: _____ Birth Weight: _____ Apgar Scores: _____

Developmental History:

How would you describe your child's temperament as an infant?

Give the age your child did the following:

❒ Rolled Over ❒ Used Single Words ❒ Used Simple Sentences

❒ Sat with Support ❒ Toilet Trained (Bladder) ❒ Toilet Trained (Bowel)

❒ Walked with Help ❒Walked without Help ❒Rode Two Wheel Bicycle

❒Fed Self

HEALTH

Does your child have any prolonged illness, medical or physical problems? ❒ Yes ❒ No

If yes, please describe:

Check any that apply to your child:

❒ Headaches ❒ Bed Wetting ❒ Daytime Wetting

❒ Attention Difficulties ❒ Hyperactivity ❒ Coordination Problems

❒ Has entered Puberty

Does your child have any allergies? ❒ Yes ❒ No

If yes, please describe:

Does your child currently take any medication? ❒ Yes ❒ No

If yes, list medication and dosage:

Is your child on a special diet? ❒ Yes ❒ No

If yes, please describe:

Has genetic testing been done? ❒ Yes ❒ No
If yes, please describe:

Are there any blood relatives with neurological, developmental or learning problems? ❒ Yes ❒ No
If yes, please describe:

Does your child see a physician regularly? ❒ Yes ❒ No
If yes, please list name and telephone numbers:

EVALUATIONS AND SERVICES
Please list practitioners and/or agencies that have provided services to your child.

Name	Phone No.	Reason for Service	Dates