Warren County Christian School
Student Health History

Student Name: ____

Date of Entry at WCCS: ____________________________________

HEALTH HISTORY:

Check any of the following illnesses the child has had:

___ "Red" measles	___ German or 3-day measles	___ Whooping Cough
___ Chicken Pox	___ Rheumatic Fever	___ Pneumonia

Please circle your response to each of the following: (If you require extra space for explanations, please feel free to attach additional pages.)

Has the child had more than six colds or throat infections, with a fever, per year? Yes No

Has the child had any trouble with ears or hearing? Yes No

Has the child had any trouble with eyes or seeing? Yes No

Has the child had any trouble with teeth? Yes No

Has the child had a convulsion or seizure in the past year? Yes No

If so, how many? ________ Treatment: ____

Has the child ever had a fainting spell? Yes No

Does the child frequently complain of headaches? Yes No

Has a doctor ever said the child had a heart murmur? Yes No

Does the child have trouble keeping up physically with peers? Yes No

Do any foods disagree with the child? Yes No

Does the child frequently have diarrhea? Yes No

Has constipation been a recurrent problem for this child? Yes No

Has the child ever been diagnosed with worms or parasites? Yes No

Has there ever been blood in the child's bowel movements? Yes No

Has the child ever had jaundice or liver trouble? Yes No

Does the child frequently complain of stomach aches? Yes No

Does the child have any problems with urination? Yes No

Does the child have any skin problems? Yes No

Has the child ever been diagnosed with allergies? Yes No

If so, please give details of allergens, symptoms, and treatment: ____________________

____

Does your child require a special diet? Yes No
If so, please explain: ____

____

Has the child ever had asthma or wheezing? Yes No

Has the child ever had an adverse reaction to medication or injections? Yes No

If so, what was the medication or injection? ____________________________________

Does the child have any difficulty breathing through the nose? Yes No

Does the child snore at night? Yes No

Does the child frequently complain of arm or leg pain? Yes No

Has the child ever exhibited limping or swelling of any joints? Yes No

Has any abnormality in the child's blood ever been diagnosed? Yes No

Does the child frequently have difficulty sleeping? Yes No

Has the child ever had a positive skin test for tuberculosis? Yes No

Has the child ever had any serious illnesses, accidents, or operations? Yes No

If so, what and when: ____

____

Does the child regularly go to a hospital, clinic or doctor? Yes No
If so, for what and how often? ____

Apart from vitamins, does the child regularly take any medications? Yes No

If so, what? ____

Does the child need to take any medications during school hours? Yes No

If so, what? _________________________ Dosage _____________ Frequency _____

Is the child regularly under the care of a dentist? Yes No

If so, name of dentist: ____

Please circle any of the following that frequently concern you about your child:

Bedwetting	Wetting during the day	Nightmares
Temper tantrums	Thumb sucking	Defiant behavior
Unclear speech	Disobedience	Easily upset
Lying	Excessive Restlessness	Selfishness
Excessive shyness	Excessive sibling rivalry	Unexplained sadness
Combative behavior	Destructive of property	Day dreaming
Overeating	Low appetite	Emotional dependence

Other: ____

This health history has been provided on _________________________________ by
Date

____________________________________ ______________________________
Name Relationship to Child