Wayne
Township Public Schools

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To Parent: The purpose of gathering this data is to assist the school personnel to better serve your child in the educational environment.
Please complete this form at registration.

HEALTH APPRAISAL

Name_____Birth date_____

Address_____School_____

Parent's Name_____

SIGNIFICANT HEALTH HISTORY

Has your child had any of the following diseases?

Allergy _____
Asthma _____
Convulsions _____
Diabetes _____
Ear Infections/Fluid _____
Eczema _____
Heart Disease including _____
Rheumatic Fever _____
Kidney/Bladder problems _____
Meningitis _____
Scarlet Fever _____
Tuberculosis _____
Whooping Cough _____
Other (specify) _____

Has your child had any of the following?

Accidents _____
_____
_____

Operations_____
_____
_____

Hospitalizations _____
_____
_____

Does your child have any handicapping conditions?

Congenital _____
Deformities _____
Hearing _____
Vision _____
Orthopedic _____
Birth Injury _____

GROWTH AND DEVELOPMENT

Did your child have a normal birth?

Weight at birth?_____Age of walking_____Age of first words _____.

Age of first sentence_____.

Does your child have brothers and sisters? Names and Ages _____

_____

Did your child have any special growth and developmental problems in the pre-school years? _____

_____

Does your child show good coordination?_____

Does your child show preference for his right or left hand? _____

Does anyone have difficulty understanding your child? _____

Does your child understand and respond to directions and questions? _____

_____

Does your child understand and/or speak a language other than English? _____

_____

Has your child had high fevers and/or frequent illnesses? _____

_____

What medications (prescribed or over-the counter) have been or are currently given to your child? _____

_____

What medical treatment, if any, is your child presently receiving? _____

_____

Does your child have any of the following: bedwetting, disturbed sleeping patterns, special fears, nightmares, finger sucking, nail biting, nervous tendencies, sensitive, over active, cries easily, poor eating habits, rocking patterns, temper tantrums, other? Please comment on those that pertain to your child _____

_____

_____

Physician's name _____Address _____

Has your child had his/her speech language hearing evaluation? _____When? _____

Name _____ Address _____

Has your child seen a psychiatrist or psychologist? _____When? _____

Name _____ Address _____

In your opinion is your child healthy? _____

Is there any other information that would be helpful in planning for your child's school experience? _____

_____

Date _____ Parent's Signature _____