AVON ELEMENTARY SCHOOL
Lincoln and Fifth Avenues
Avon-By-The-Sea, New Jersey 07717
www.AvonSchool.com

Mrs Jaime Golda *School Nurse*
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PARENT HEALTH QUESTIONNAIRE

CHILD'S NAME_____

BIRTHDATE_____ SEX_____

ADDRESS_____

WITH WHOM DOES THE CHILD LIVE?_____

WHO IS LEGAL GUARDIAN?_____

NAME OF CHILD'S DOCTOR_____

PERINATAL AND DEVELOPMENT HISTORY

1. Did the mother have any unusual problems/illness during the pregnancy of the birth such as breech, forceps or caesarean delivery? Yes_____ No_____

   If yes, briefly explain:_____

2. Was the infant born full term_____ Early _____ Late_____

3. What was the infant's birth weight?_____

4. Did the infant have any sickness of problems while in the hospital, such as yellow jaundice, blue spells or convulsions? Yes _____ No_____

   If yes, briefly ex plain:

5. Please give approximate age at which the child: sat up alone_____walked_____ said single words_____said sentences_____was toilet trained_____

6. How does this child's development compare to other children, such as brothers, sisters or playmates? About the same_____slower_____ faster_____

7. **Does your child have allergies**?

8. **If your child does have allergies, does he/she take medication or treat the allergy? If so, please specify medication taken**:

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HEALTH CONDITIONS (please check all applicable)

_____ chicken pox (what year?_____)

_____diabetes

_____ eye problems, poor vision or crossed eyes

_____ frequent ear infections

_____ tubes in ears

_____ toothaches/dental infection

_____ frequent sore throat infections

_____ Is your child sick often?

_____ high fevers

_____ poor hearing

_____seizures or epilepsy

_____ sickle cell disease

_____ frequent headaches

_____ frequent nosebleeds

_____others, list:

If so, please explain:_____

_____ _____

Date Parent/Guardian Signature