St. Albert the Great School

Health and Learning History

Student's name	Sex	Date of Birth
	☐ Male ☐ Female	/ /

Family Health and Learning History Please list allergies, heart problems, diabetes, cancer or other serious health conditions. Also, please list learning history of family members such as autism, dyslexia, ADD/ADHD, auditory processing, learning disabilities or difficulties with memory, reading or math.

Father
Mother
Brothers and Sisters

Birth and Developmental History ☐ No unusual birth or developmental history

Did the mother have any unusual physical or emotional illness during this pregnancy? ☐ Yes ☐ No

Was infant born full term? ☐ Yes ☐ No Did the infant have any sickness or problems? ☐ Yes ☐ No

Briefly explain illness or problems.

How does the child's development compare to other children, such as his or her brothers/sisters or playmates?

☐ About the same ☐ Delayed ☐ Advanced

Student Health and Learning

☐ **YES,** my child receives regular medical/health care for the following conditions:

- ☐ Allergies
- ☐ Asthma
- ☐ ADD/ADHD
- ☐ Autism
- ☐ Behavior concerns
- ☐ Birth/congenital malformations
- ☐ Bone/muscle/joint problems
- ☐ Blood problems
- ☐ Bowel/bladder problems
- ☐ Cancer
- ☐ Cystic fibrosis
- ☐ Diabetes
- ☐ Depression
- ☐ Ear problem/hearing difficulty
- ☐ Emotional concerns
- ☐ Headaches
- ☐ Heart problems
- ☐ Hemophilia
- ☐ Juvenile arthritis
- ☐ Lead poisoning
- ☐ Migraines
- ☐ Neuromuscular disorder

☐ **NO** medical conditions

- ☐ Seizure disorder
- ☐ Sickle cell anemia
- ☐ Skin conditions
- ☐ Speech problems
- ☐ Traumatic brain injury
- ☐ Vision problems (glasses, contacts)
- ☐ Currently under a doctor's care. For what?

_____

- ☐ Other_____
- ☐ Other_____

Please explain any conditions above or any reasons for hospitalizations.

Please indicate any allergies your child may have.

Allergy type	Reaction	School restrictions or recommended actions
☐ Bee/Insect		
☐ Food		
☐ Medication		
☐ Other		

Health and Learning History continued

Please list any prescription and over the counter medication that your child takes on a regular basis.

Medication and dose	Time	Reason

Do any health and/or medical conditions require school restrictions, modifications, and/or intervention?

☐ Yes ☐ No If YES, please explain.

Does the student require any special procedures and/or treatments for their health condition(s)?

☐ Yes ☐ No If YES, please explain.

Please indicate any other information about your child's health or development that you think would be helpful for the school to know.

First word at age: Any problems learning to talk:

Potty trained: YES NO Dresses self: YES NO

Form completed by	Relationship to student	Date / /