Paradise Valley Unified School District No. 69

STUDENT HEALTH HISTORY

To be completed by parent/guardian at the time of registration.

STUDENT NAME: ______________________________ DATE OF BIRTH: ______________

SCHOOL: ______________________________ AGE: ________ GRADE: ________

Has child previously attended school in the Paradise Valley Unified School District? ☐ YES ☐ NO

If yes: Name of School: ______________________________ Year Attended: ________

(Has your child been/Is your child presently) under treatment of a physician, counselor, and/or psychologist? ☐ YES ☐ NO

If yes, please provide: Name of Provider: ____________________ Date Last Seen: ____________

Reason: ______________________________

Has your child ever had a psychological test? ☐ YES ☐ NO Date of Test: ____________

PRENATAL HISTORY

During pregnancy, did the mother:

	YES	NO
Have prenatal care?	☐	☐
Have health problems?	☐	☐
Incur any serious accident or injury?	☐	☐

BIRTH HISTORY

Birth weight ______ lbs. ______ ozs. length ________

	YES	NO
Was birth premature?	☐	☐
Caesarean delivery?	☐	☐
Any birth injuries/defects?	☐	☐

INFANT DEVELOPMENT

Within the first 2 years of life, did your child display normal (average) or delayed development in the following events:

	NORMAL	DELAYED
Sit alone (avg. 7 mos.)	☐	☐
Crawl (avg. 9 mos.)	☐	☐
Stand alone (avg. 10 mos.)	☐	☐
Walk alone (avg. 12 mos.)	☐	☐
Speak first word (avg. 12 mos.)	☐	☐
Speak first sentence (avg. 24 mos.)	☐	☐
Become toilet trained (avg. 24 mos.)	☐	☐

BEHAVIORAL HISTORY

Has your child ever exhibited any of the following:

	NEVER	SOMETIMES	ALWAYS
Bites nails	☐	☐	☐
Difficulty sleeping	☐	☐	☐
Fights with others	☐	☐	☐
Frequent crying	☐	☐	☐
Nightmares	☐	☐	☐
Poor coordination	☐	☐	☐
Poor eating habits	☐	☐	☐
Prefers to play alone	☐	☐	☐
Restlessness/hyperactivity	☐	☐	☐
Sucks thumb	☐	☐	☐
Tantrums	☐	☐	☐
Teeth grinding	☐	☐	☐
Wets the bed	☐	☐	☐

MEDICAL HISTORY

Has your child ever had or been diagnosed with:

	YES	NO
ADD/ADHD	☐	☐
Allergies	☐	☐
Anemia	☐	☐
Arthritis/Rheumatic Disease	☐	☐
Asthma	☐	☐
Autism	☐	☐
Birth Defect/Developmental Disorder	☐	☐
Bleeding Disorder	☐	☐
Connective Tissue Disorder	☐	☐
Cystic Fibrosis	☐	☐
Diabetes	☐	☐
Eating/Weight Disorder	☐	☐
Emotional Disorder	☐	☐
Endocrine Disorder	☐	☐
Gastrointestinal Disorder	☐	☐
Genitourinary Disorder	☐	☐
Hearing/Ear Disorder		
• Known hearing loss	☐	☐
• Tubes in ears	☐	☐
• Hearing aids	☐	☐
• Frequent ear aches/infections	☐	☐
Heart Condition	☐	☐
Hypertension	☐	☐
Malignancy	☐	☐
Neuro Disorder (includes migraines)	☐	☐
Orthopedic Disorder	☐	☐
Physical Handicap	☐	☐
Psychiatric Disorder	☐	☐
Scoliosis	☐	☐
Seizure Disorder	☐	☐
Serious Injury/Accident	☐	☐
Sickle Cell Disease	☐	☐
Skin Disorder	☐	☐
Speech Disorder	☐	☐
Substance Use/Abuse	☐	☐
Surgery	☐	☐
Tuberculosis (active)	☐	☐
Vision/Eye Disorder		
• Known vision loss	☐	☐
• Color deficient	☐	☐
• Glasses/contacts	☐	☐

PARENT/GUARDIAN SIGNATURE: ______________________________ DATE: ____________