Galt Joint Union Elementary School District

1018 C Street, Suite 210, Galt, CA 95632
209-744 4521 / 209-745-5479 fax

STUDENT HEALTH APPRAISAL

Student's full name: ____Birthdate: _________________________

Person completing this form and relationship to child: ____Today's date: _____________

Family medical history – Do any of this child's relatives have any of the following? Indicate Relation to student?

☐ Allergies	☐ Blood disease	☐ Epilepsy	☐ Learning problems
☐ Asthma	☐ Cancer	☐ Heart disease	☐ Mental illness
☐ Arthritis	☐ Cerebral Palsy	☐ High blood pressure	☐ Thyroid disease
☐ Birth defects	☐ Diabetes	☐ Hyperactivity	☐ Tuberculosis

Additional information____

____

Student's Medical History

PAST | CURRENT	PAST | CURRENT
☐ ☐ Allergies/to what:	☐ ☐ Epilepsy
☐ ☐ Anemia (iron deficiency)	☐ ☐ Fevers, above 104°
☐ ☐ Asthma (wheezing, shortness of breath)	☐ ☐ Head injury
☐ ☐ Bladder/kidney problems	☐ ☐ Headaches, frequent
☐ ☐ Bleeding problems	☐ ☐ Heart condition (murmur)
☐ ☐ Bronchitis (upper respiratory infections)	☐ ☐ Hyperactivity (ADHD)
☐ ☐ Colds, frequent	☐ ☐ Orthopedic problems (bone/joint)
☐ ☐ Dental problems	☐ ☐ Skin condition
☐ ☐ Diabetes	☐ ☐ Sleeping disorder
☐ ☐ Ear infections (chronic)	☐ ☐ Tonsillitis, recurring
☐ ☐ Eating disorder	☐ ☐ Tuberculosis contact enuresis
☐ ☐ Enuresis (bed-wetting)	☐ ☐ Other

Additional information____

____

What has been this child's most serious health problem to date? ____

____

____

Hospitalizations, operations:
____

____

Accidents (stitches, broken bones); ____

____

Is this child currently taking any medications (prescription or over the counter)? ☐ yes ☐ no

Medication name/dose/schedule: ____

For what condition? ____

Student birth and development history

Was delivery ☐ Full term ☐ Premature ☐ Late Was labor induced? ☐ yes ☐ no Birth weight____________

Length of labor_____________ Baby's delivery position (presentation)_____________________________

Type of delivery: ☐ Vaginal ☐ Instrument ☐ Caesarian ☐ Planned ☐ Emergency: Was anesthesia used? ☐ yes ☐ no APGAR score: ________

Circumstances at birth: ☐ Cord around neck ☐ Difficulty breathing ☐Resuscitation needed ☐ Oxygen administered ☐ Convulsions

☐ Blood transfusion ☐ Jaundice ☐ Bilirubin lights ☐ Other

Length of hospital stay________________ Were parent and baby discharged together? ☐ yes ☐ no

☐ Breast fed ☐ Bottle fed ☐ Formula ☐ Combination ☐ Sucking/latching difficulties ☐ Feeding problems ☐ Colicky

Normal weight gain ☐ yes ☐ no When was first solid food introduced? _____________________

Age when weaned from bottle/breast ___________________ Sleeping difficulties past or current____

Developmental History- At what age did this child:

Sit alone __________Crawl ____________ Walk alone _______________ Use three-word sentences ____________________

Potty train/bladder ______________ Potty train/bowel _______________

Are any of these milestones considered slower or faster than siblings? ☐ yes ☐ no

If yes, which ones ____

Did this child's development slow or stop at any time? ☐ yes ☐ no

Student Social/Emotional and School History

Student's disposition- Describe how this child relates to family members (parents/siblings), other adults & children:

____

Describe his/her general personality/temperament____

Favorite recreational activities/hobbies/skills____

Responsible for own actions? Dependable? ____

Major factors which affect child's behavior: ____

At-Home Behaviors – Child usually sleeps from _____p.m. to _____a.m. Difficult to awaken in the morning? ____

Unusual sleeping problems? (restlessness, nightmares, bedwetting) ____

Does this child sleep alone or share bed/room (with whom)? ____

Hours of television watched daily? __________________Type of programs? ____Monitored? ___________________________________

Unusual eating problems/patterns? ____

Balanced diet? /special diet? ____

What home responsibilities does this child perform regularly? ____

Method of discipline at home ______________________________________Who disciplines? ____

How does this child display anger? _ ____

What do you perceive as this child's difficulties or problems at home? ____

____

What do you enjoy most about this child? ____

____

Stressful Situations – *Please mark those situations that might have brought stress to this student and indicate the month/year of occurrence. Write additional comments below*

____Death of a parent	____Marriage/remarriage of parent	____ Death of friend or pet
____Death of a sibling	____Temporary family separation	____Difficulties with relative(s)
____Extended separation of parents for any reason(specify)________________________________	____Major change in family members health or behavior	____Alcohol/drug use in family
____Divorce of parents	____Diagnosed terminal illness for any family member	____Unplanned parental job loss
____Conflict with parents/siblings	____Recent pregnancy/birth of sibling	____Sibling leaving home
____Death of a close relative	____Mother going to work or school	____Recent move to new city
____Physical or sexual abuse of the child, sibling, or parent	____New family living arrangements or change in living conditions	____Numerous family moves
____Major personal illness/injury	____ Recent family difficulties	____Family financial problems
____Other (Specify below)		

What do you perceive as this child's difficulties at school ____

Physical problem interfering with academic achievement (vision, hearing)? ____

Number of schools attended to date? __________________

Previous interventions (speech therapy, Special Ed.) ____

What do you believe should be done to help this child in school? ____

What would you like to see in this child's future? ____

List all Physician's providing health care:

____

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