



SOUTH BEND COMMUNITY SCHOOL CORPORATION

Parent Health Questionnaire

TO BE ANSWERED BY PARENT/GUARDIAN:

Name of student: _____ Date of Birth: _____

Address: _____ Phone: _____

School Attending: _____ Date: _____

HEALTH HISTORY

Early Development

Full Term/ Premature: _____ Weight at birth: _____

Jaundice at birth (Y/N): _____ Jaundice later (Y/N): _____

Began to sit up at: _____ months

Began to walk at: _____ months

Began to say words at: _____ months

This child is _____ (number) in a family of _____ (number) children.

Did your child ever have convulsions? (Y/N) _____

Did your child have feeding problems? (Y/N) _____

Did your child suffer from frequent high fevers? (Y/N) _____

Severe/Frequent illness: _____

Severe Injuries: _____

Operations: _____

Special Treatments: _____

Are there any conditions present that should be considered in planning your child's educational program? _____

Date: _____ Parent Signature: _____