Masada Charter School

365 West Cannon Ave. Box 2277 Centennial Park AZ 86021

Student Information for Health & Developmental History

Personal Information

Student:_____ D.O.B. _____ [M] [F] Date Completed: _____

Father's Name _____ Mother's Name_____

Street Address _____City_____State_____Zip_____

Home Telephone # _____ Work Phone # _____

Medical Allergies_____
_____.

Medical Conditions_____
_____.

Birth History

Did you have any illnesses during the pregnancy?	Y	N	Explain	_____
Did the baby come on time?	Y	N	Explain	_____
Were there any problems with the delivery	Y	N	Explain	_____
Did the baby have a birth defect?	Y	N	Explain	_____

Baby's Birth weight: [____] lbs [____] oz [____] length

Number of previous   Pregnancies [   ]   Miscarriages [   ]   Still births [   ]

Health History

Has your child ever had the following?

[ ] Chicken pox _____	[ ] Asthma	[ ] Rheumatic Fever	[ ] Serious Accident
[ ] Mumps	[ ] Seizures	[ ] Scarlet Fever	[ ] Hospitalization
[ ] Whooping Cough	[ ] Diabetes	[ ] Strep Infection	[ ] Poison Ingestion
[ ] Measles	[ ] Tuberculosis	[ ] Ear Infections	[ ] Other:
[ ] Rubella	[ ] Anemia	[ ] Kidney Infections	_____

Is your child currently taking medicine?   Y   N   List _____

Is your child allergic to anything?   Y   N   List _____

Have any of your children died?   Y   N   Explain _____

Has your child been:	**slow**	**average**	**fast**	**Has your student had problems with the following:**	
Walking	[ ]	[ ]	[ ]	[ ] Coordination	[ ] Teeth
Talking	[ ]	[ ]	[ ]	[ ] Sight	[ ] Hearing
Schoolwork	[ ]	[ ]	[ ]	[ ] Fainting	[ ] Accidents
Getting along with others	[ ]	[ ]	[ ]		

Family Health History

Has any blood relative on either side of the family had any of the following?

[ ] Asthma	[ ] Heart disease	[ ] Kidney disorder	[ ] Seizures
[ ] Cancer	[ ] Heart attack	[ ] Mental disorder	[ ] Other hereditary disorders:
[ ] Diabetes	[ ] Hearing defect	[ ] Allergies	_____

Immunization History

	Date	Date	Date	Date	Date
DTaP/Td					
IPV/OPV					
MMR					
HiB					
Hep B					
HepA					
Varicella					
Other					

Immunization records are on file at:_____

* If claiming exempt from immunizations for this child, a signed exemption statement must be on file at the school.

      [ ] No, I do not request exemption

      [ ] Yes, I claim exemption and have signed the exempt statement.

Parent Signature: _____ Date: _____

Reviewed by Health Provider: _____ Date: _____