POCONO MOUNTAIN SCHOOL DISTRICT
DEVELOPMENTAL HISTORY

Student Name

Date of Birth **Entry Grade**

BIRTH HISTORY:

Normal Delivery? Yes☐ No ☐ Birth Weight Lbs. Oz.

Was birth premature? Yes ☐ No ☐ Was Labor prolonged? Yes ☐ No ☐

Was this a normal delivery? Yes ☐ No ☐ Was this a Cesarean section? Yes ☐No ☐

Did child have complications at birth? Yes ☐No ☐

Was child in an incubator? Yes ☐No ☐

Were there any complications during pregnancy? (Bleeding, infection, German measles, medications, other) Yes ☐No ☐

If you answered YES to any question above, please explain.

INFANCY AND EARLY CHILDHOOD:

Age of Walking Alone

Age of bladder training

Age of first words

Age of Bowel training

Age of First Sentence

HOME AND OTHER EXPERIENCES: Please check those agencies where your child or family has received care or assistance:

Headstart ☐ Project Connect ☐ I.U. 20 ☐
Public Assistance ☐ EPSDT Screening ☐ Well Baby Clinic ☐
Dept. of Public Health ☐ Children & Youth ☐ Mental Health ☐

Has your child shown any of the following?

Feeding problems? Yes ☐No ☐
Unusual Sleep Patterns? Yes ☐No ☐
Poor coordination? Yes ☐No ☐
Bed wetting? Yes ☐No ☐
Behavior problems? Yes ☐No ☐
Other habits or problems? Yes ☐No ☐

MEDICAL HISTORY:

Allergies to **food**? (List)
Type of reaction?
Intervention necessary?

Allergies to **medications**? (List)
Type of reaction?
Intervention necessary?

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Allergy to Bee Stings? Yes ☐No ☐ Need medication when stung? Yes ☐No ☐
If YES, please indicate medication needed

Serious Illnesses or Hospitalizations?

Surgery?

Special dietary needs?

Has child received speech therapy? Yes ☐No ☐

Does child wear hearing aids? Yes ☐No ☐

Does child wear glasses? Yes ☐No ☐ Reading? ☐ Distance? ☐ Both? ☐

Does child have problems running? Yes ☐No ☐ Jumping? Yes ☐No ☐

Does child wear orthopedic shoes? Yes ☐No ☐ or inserts? Yes ☐No ☐

If you answered YES to any question above, please explain.

Check one of the following boxes regarding Varicella (Chickenpox) Immunity:

☐ Date of Varicella Vaccine

☐ Date of Varicella Lab Evidence

☐ Approximate *date* of chickenpox

Age of Chickenpox

☐ Child has not have Varicella vaccine or Chickenpox

All students in Kindergarten, First Grade (original entry) and Seventh Grade **must have** proof of vaccination or a written statement that the child has had chickenpox.

Does your child have a specific medical condition? Yes ☐No ☐
If yes, please describe:

Does your child have health problems which might, in your opinion affect your child's school work or physical education program: Yes ☐No ☐
If yes, please explain:

Is your child currently under medical treatment? Yes ☐No ☐
Reason:

Is your child currently taking medication? Yes ☐No ☐
Name of medication (s):

ALL MEDICATIONS, GIVEN IN SCHOOL, NEED DOCTOR'S WRITTEN NOTE AND PARENT'S SIGNED PERMISSION SLIP

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KINDERGARTEN ENTRY:
Does your child have brothers or sisters? Yes ☐No ☐

If Yes, how many brothers? Sisters? Ages?

Has your child attended nursery or pre-school? Yes ☐No ☐ Where? How Long?

Any other experiences (Day Care, Sunday School, Babysitter)?

Does your child have playmates his own age? Yes ☐No ☐

In your neighborhood? Yes ☐No ☐

Do you have any concerns not mentioned above?

____________________________ ____________________________
Parent / Guardian Signature Date

PLEASE COMPLETE ALL THREE PAGES OF FORM AND SIGN THIRD PAGE.

THANK YOU.