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Little Keswick School

Incorporated

A Therapeutic, Special Education Boarding School for Boys
www.littlekeswicksschool.net

P.O. Box 24
Keswick, VA 22947

MEDICAL HISTORY OF A CHILD

PARENT/GUARDIAN: Please fill out this form as completely as possible. Please indicate where information is **not applicable (N/A)** or **unknown (UNK)**. Be sure to sign and date the form. We cannot enroll your child into our program unless this form is on file with us.

1. Child's name and address: _____

2. Date of birth: _____ 3. Place of birth: _____

4. Sex of child: Male Female 5. Present Height: _____ 6. Present Weight: _____

7. Name and age of all children in the family: _____

8. Mother's (inc. maiden) name: _____

9. Father's full name: _____

10. Describe any serious illnesses or chronic conditions of child's parents and siblings, if known:

Check, if applicable: None Unknown

11. About the child, describe the following:

a. Past serious illnesses or infectious diseases (name of disease, duration, etc.): _____

b. Serious injuries: _____

c. Hospitalizations: _____

d. Impact of any of these on current health: _____

e. Physical handicaps: _____

f. Visual disorder: _____

g. Hearing problems: _____

h. Communication problems: _____

i. Sexual health and reproductive history: _____

12. Examinations the child has had (copies may be attached, if available):

a. Psychological (dates, place, type of test or examinations and results): _____

b. Psychiatric (dates, place, type of test or examinations and results): _____

c. Neurological (dates, place, type of tests or examinations and results): _____

d. Speech (dates, place, type of tests or examinations and results): _____

e. Occupational therapy (dates, place, type of tests or examinations and results): _____

13. Drug Usage Profile: Please list all prescription and non-prescription drugs used during the past six months and all behavioral control or anti-convulsant medication.

NAME OF DRUG USED	DOSAGE	FIRST AND LAST DATES TAKEN
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

14. List any ineffective chemotherapy (behavior control medications):

NAME OF DRUG USED	DOSAGE	DATES TAKEN	RESPONSE
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

15. Wetting: Day Night

If yes, describe any patterns: _____

Soiling: Day Night

If yes, describe: _____

16. Describe dental health: _____

Date of last dental checkup: _____

17. Describe general medical health and fitness: _____

Date of last examination: _____

18. Allergies/allergic reactions to plants, foods, insects, etc.: _____

EMERGENCY PROCEDURES ADVISED (if applicable): _____

19. Other important medical information: _____

Parent/Guardian signature: _____ Date: _____

Your phone numbers: (Home) _____ (Work) _____