

GALLIA COUNTY LOCAL SCHOOLS
CONFIDENTIAL HISTORY FORM

Today's Date _____

Parent: This information will be used to help us understand and work with your child. It is your privilege to omit any questions you find objectionable.

Child's Name _____ Birthdate _____

Father's Name _____ Birthdate _____

Mother's Name _____ Birthdate _____

Father's general health _____ Mother's general health _____

Are parents living together? Yes No (please circle)

Is there a step-parent living in the home? Yes No Other relative in the home? Yes No

Name of your child's doctor _____

Number of brothers _____ Number of sisters _____

Have any of the children had any serious illness? Yes No

If yes, please explain _____

Family History: Have any of the child's family (cousins, aunts, uncles, grandparents, brothers, sisters, parents) had any of the following?

Epilepsy or Seizures	Mental Illness	Tuberculosis	Birth Defects	Cerebral Palsy	
Diabetes	Allergies	Blindness	Deafness	Special Education	Mental Retardation

Please explain _____

Have any of your children died? Yes No Cause _____

Is the child adopted? Yes No At what age? _____

Pregnancy and Birth

At what month of your pregnancy did you go to the doctor? _____

Did you have any illness, injury, or infection during pregnancy? Yes No

If yes, explain briefly _____

Any exposure to alcohol or smoking? Yes No Take any medications? Yes No

Length of active labor _____ Was infant full-term? _____

Birth weight _____ Type of Delivery (circle) Natural Breech Caesarean (C-section)

Was it necessary to give the infant oxygen? Yes No How long? _____

Is the child a twin? Yes No

