



JFH Educational Academy Inc.

Jolly Fun House Playschools • Jolly Fun Day Camp

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HEALTH HISTORY

PLEASE SIGN AND RETURN TO THE OFFICE

Child's Name _____ Birth date _____ Age _____

A. PRENATAL HISTORY

1. Was mother's age (under 17 or over 35) at time of birth: ___ Yes ___ No.
2. Did mother gain (under 20 lbs. or over 40 lbs.) during pregnancy? ___ Yes ___ No.
3. Did you have prenatal care? ___ Yes ___ No If yes, what month of pregnancy did prenatal care begin? _____
4. Were there any health problems/complications/injuries during your pregnancy? Yes ___ No ___
If yes, explain _____
5. Were there any complications/problems during labor or delivery for the mother or the child?
Yes ___ No ___ If yes, explain _____
6. Birth weight ___ lbs. ___ ozs. Was your child full term? ___ Yes ___ No If no, number of months _____

B. HEALTH

1. Did your child have any medical illnesses at birth or within the first year of his/her life? Yes ___ No ___
If yes, explain _____
2. Has your child had a serious accident in the past? ___ Yes ___ No Head injury? Yes ___ No ___
If yes, explain _____
3. Does your child seem well most of the time? ___ Yes ___ No
4. Has your child ever had any serious health problems? ___ Yes ___ No
If yes, explain _____
5. Does your child have health problems now? ___ Yes ___ No
If yes, explain _____
6. Is your child taking any medication now (including aspirin, laxatives, vitamins, etc.)? Yes ___ No ___
If yes, what medication? _____ Why? _____
7. In a year, has your child had as many as three (3) ear infections? ___ Yes ___ No
8. Are you concerned about your child's hearing? ___ Yes ___ No
9. In a year, does your child have more than 3 colds or sore throat infections with a fever? ___ Yes ___ No
10. Are you concerned about your child's eyes or vision? ___ Yes ___ No
11. Has your child ever been seen by a medical specialist? ___ Yes ___ No If yes, explain _____
12. Does your child have any special needs? ___ Yes ___ No If yes, explain _____
13. Has your child ever been hospitalized? ___ Yes ___ No If yes, explain _____
14. Is your child allergic to any foods or substances? ___ Yes ___ No If yes, to what? _____

(Ask for Food Allergy Action Plan form)

C. TOILETING

1. Is your child potty trained? ___ Yes ___ No If yes, at what age? _____
2. What word does your child use for: urination? _____ bowel movement? _____
3. What is the frequency of your child's bowel movement? _____

D. DEVELOPMENTAL HISTORY

- 1. How do you comfort your child? _____
- 2. What are your child’s favorite toys? _____
- 3. What are your child’s favorite activities? _____
- 4. Can your child?
 - Feed himself/herself using a spoon and/or a fork? ___ Yes ___ No
 - Wash and dry his/her own hands? ___ Yes ___ No
 - Help with dressing or dress with little assistance? ___ Yes ___ No
 - Speak so that he or she can be understood by others? ___ Yes ___ No
 - Express his or her thoughts and needs easily? ___ Yes ___ No
- 5. Do you have any concerns about your child’s appetite or willingness to try different foods?
If yes explain: _____
- 6. Has your child ever had trouble walking, climbing, reaching, holding on to things? ___ Yes ___ No
If yes explain: _____

E. SLEEPING AND EATING HABITS

1. Sleeping Habits

- a. Do you have any special ways of helping your child go to sleep? ___ Yes ___ No How? _____
- b. Does your child cry when going to sleep? ___ Yes ___ No
- c. What is your child’s current sleeping schedule?
Night time: From _____ to _____
AM nap: From _____ to _____
PM nap: From _____ to _____
- d. Does your child use a pacifier at home? ___ Yes ___ No **School:** Infants and naptime only for Toddlers
- e. Does your child have a special blanket? ___ Yes ___ No

2. Feeding Habits

- a. **Infant Program:** Was your baby breast fed? ___ Yes ___ No: Is baby still breast feeding? ___ Yes ___ No
- b. Type of formula: _____
- d. What is your child’s present eating habit? Choose one phrase to describe each meal below.
Not Hungry - At school we refer to as the “**No Thank You Portion**”, means a taste or two of some items.
Eats Well – At school we would choose if child ate most of firsts.
Eats A Lot - At school child ate firsts and came back for seconds.
Breakfast _____
Lunch _____
Snack _____
Dinner _____
- e. Has your child had any eating problems? ___ Yes ___ No If yes, explain _____

Are there other things you would like to tell us about your child? _____

PLEASE SIGN AND RETURN TO THE OFFICE with a copy of your child’s birth certificate.

Print Parent Name

Parent’s Signature

Date