



# 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**)

15. Please note **any birth marks or Mongolian spots:** \_\_\_\_\_

#### 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? \_\_\_\_\_

