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Little Keswick School
Incorporated
A Therapeutic, Special Education Boarding School for Boys
www.littlekeswickschool.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) ______________