Pre-K & Kindergarten Health Information

Student's Name_____ Gender_____

Date of birth_____ Place of birth_____

Mother_____ Mother's maiden name_____

Father_____

Child lives with_____

Names of other adults in home_____

Child's physician_____

Hospital preferred_____

Developmental History:

Length of pregnancy _____weeks Premature? _____ Birth weight _____ C-section? _____

Any problems with pregnancy, labor and delivery or shortly after birth (bleeding, infections, diabetes, breathing problems, seizures, jaundice, etc)? _____

Any problems with nightmares, temper tantrums or phobias (please describe)?_____

Vision:

Has your child had a professional vision exam? _____ If so, when? _____

Please answer yes or no to the following regarding any complains or anything you have noticed:
Complaints of headaches_____
Burning or itching eyes_____
Sensitive to light_____
Squinting_____
Covering or closing one eye_____
Does your child currently wear glasses? _____

Hearing:

Has your child had a professional hearing examination? _____ If so, when? _____

Please answer yes or no to the following regarding any complaints or anything you have noticed:
Is there a history of frequent ear infections? _____
Does your child have P.E. tubes? _____
Do you have any concerns regarding your child's hearing? _____ If so, please explain: _____

Are there any other health concerns or issues? _____

Please check yes or no to the following information and add any pertinent information:

Serious head injury	☐Yes ☐No	Joint pain/swelling	☐Yes ☐No
Loss of consciousness	☐Yes ☐No	Limits of movement	☐Yes ☐No
"Lazy eye"	☐Yes ☐No	Fracture	☐Yes ☐No
Glasses	☐Yes ☐No	Coordination problems	☐Yes ☐No
Ear infections	☐Yes ☐No	Hospitalizations	☐Yes ☐No
Tubes in ears	☐Yes ☐No	Operations	☐Yes ☐No
Hearing loss	☐Yes ☐No	Birth defects	☐Yes ☐No
Throat infections	☐Yes ☐No	Illness with fever	☐Yes ☐No
Heart murmurs	☐Yes ☐No	Seizures	☐Yes ☐No
Irregular heartbeat	☐Yes ☐No	Staring spells	☐Yes ☐No
Asthma	☐Yes ☐No	Allergies	☐Yes ☐No
Bronchitis/pneumonia	☐Yes ☐No	Skin conditions	☐Yes ☐No
Thyroid disease	☐Yes ☐No	Chicken pox	☐Yes ☐No
Bladder infections	☐Yes ☐No	Mono	☐Yes ☐No
Kidney disease	☐Yes ☐No	Tuberculosis in family	☐Yes ☐No
Bedwetting	☐Yes ☐No	Diabetes	☐Yes ☐No
Fecal soiling	☐Yes ☐No	Hepatitis Type ____	☐Yes ☐No
Undescended/one testicle	☐Yes ☐No	Speech problems	☐Yes ☐No
Other illness	☐Yes ☐No	Emotional problems	☐Yes ☐No

If "yes" to any of the above, please specify (please include dates, specific diagnoses and medications):

_____

_____

Will your child need medication at school? _____ If yes, please specify name of medication, times needed and reason he/she takes medication (please refer to school policy for taking medication in school):

_____