

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

---