# 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)? _____

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

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**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: _____

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Are there any other health concerns or issues? _____

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

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|---|---|---|---|
| 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):

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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):

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