



STUDENT HEALTH QUESTIONNAIRE—PRESCHOOL, KINDERGARTEN & NEW ELEMENTARY

Child's Name \_\_\_\_\_ Birth Date \_\_\_\_\_ Age \_\_\_\_\_ Sex \_\_\_\_\_  
Parent's Name \_\_\_\_\_ Date completed \_\_\_\_\_  
Doctor/Clinic \_\_\_\_\_ Date of Last Physical Exam \_\_\_\_\_ Results \_\_\_\_\_  
Dentist/Clinic \_\_\_\_\_ Date of Last Dental Exam \_\_\_\_\_ Results \_\_\_\_\_  
Form Completed by \_\_\_\_\_ Relationship to child \_\_\_\_\_  
Medical Insurance \_\_\_\_\_ Medicaid \_\_\_\_\_ CHP Plus \_\_\_\_\_ None \_\_\_\_\_

If your child is on medication, please list medication, dosage, and when taken: \_\_\_\_\_

Please list any previous medications \_\_\_\_\_

Allergies: YES NO List and describe what happens: \_\_\_\_\_

If your child has ever seen a medical specialist, please explain: \_\_\_\_\_

Date of last vision test: \_\_\_\_\_ Where? \_\_\_\_\_ Results: \_\_\_\_\_

Does your child wear glasses or contact lenses? Yes \_\_\_\_\_ No \_\_\_\_\_

Date of last hearing test: \_\_\_\_\_ Where? \_\_\_\_\_ Results: \_\_\_\_\_

List any physical disabilities: \_\_\_\_\_

Has child been hospitalized? \_\_\_\_\_ (reason and age at the time)

Has child been seen in Emergency room? \_\_\_\_\_ (reason and age at the time)

Has child had surgery? \_\_\_\_\_ (reason and age at the time)

**Family History:** Is there a family history of medical, social/emotional, or environmental concerns that might impact your child's ability to learn? Please explain any concerns: \_\_\_\_\_

**Physical Health:** Explain any health problems or concerns: \_\_\_\_\_

If your child has a medical diagnosis, what is it? \_\_\_\_\_ Age diagnosed: \_\_\_\_\_

Circle if child has had any of the following

- |                         |                         |                                    |                               |
|-------------------------|-------------------------|------------------------------------|-------------------------------|
| Frequent ear infections | Bladder/Kidney problems | Physical/Sexual Abuse              | Diabetes                      |
| Pneumonia/Bronchitis    | Stomach problems        | Sleep concerns                     | Speech concerns               |
| Asthma/Chronic Cough    | Serious injuries        | Hearing problems                   | Joint or bone problem         |
| Heart problems          | Head injury/concussion  | Dental problems                    | Hand coordination concerns    |
| Seizures                | Eating/weight concerns  | Vision problems (glasses/contacts) | Emotional/Behavioral problems |
| Skin problems           | Anemia                  | Muscle problems                    | Large muscle skill concerns   |

Comments: \_\_\_\_\_

**Pregnancy and Birth History:** Mother's age at child's birth: \_\_\_\_\_

Circle health concerns during pregnancy: Excessive nausea/vomiting high blood pressure anemia swelling

Other: \_\_\_\_\_

List medications, drugs, alcohol, or tobacco used by the mother during pregnancy: \_\_\_\_\_

Was your child born on time? \_\_\_\_\_ weeks early \_\_\_\_\_ weeks late (Circle one): vaginal birth caesarean-section

Concerns/Comments: \_\_\_\_\_

Please circle and comment on any of the following that applied to the baby: oxygen used jaundice breathing problems

feeding problems Comments: \_\_\_\_\_

Did child pass new born hearing screening? Yes \_\_\_\_\_ No \_\_\_\_\_

**Developmental History:** Age your child: walked along \_\_\_\_\_ began saying words \_\_\_\_\_ began combining words \_\_\_\_\_

Was speech clear? Yes \_\_\_\_\_ No \_\_\_\_\_ Comments: \_\_\_\_\_

Age finished toilet training: \_\_\_\_\_

**\*HEALTH PERMISSIONS\* (please circle)**

**Yes / No** I give permission for my child to be treated with Acetaminophen (non-aspirin) for pain or fever.

**Yes / No** I give permission for my child to be treated with the following approved non-prescription first aid items: calamine lotion, cortisone ointment, liquid antacid (age 12 and over), anti-bacterial soap and alcohol for cleansing, antibiotic ointment, Carmex and Vaseline for dry lips, eucerin cream, lotion, salt water gargle. (If you object to the use of any of these items, please send a note to your child's school nurse stating why the medication is to not be used. Otherwise we will interpret this as permission to all mentioned above.)

**Yes / No** I give permission for the health office to share health information with school personnel on a need to know basis

Parent/Guardian Signature \_\_\_\_\_ Date \_\_\_\_\_