IF MORE SPACE IS NEEDED, WRITE ON THE BACK OF THE FORM…

Greenwich Catholic School / Greenwich Public Schools
School Health Services **Date: _____**

KINDERGARTEN / NEW STUDENT
INTERVIEW AND QUESTIONNAIRE

Name: _____ Date of Birth_____

Male: _____ Female: _____ Twin: _____ First Child: _____ Only Child: _____

Primary Language Spoken at Home: _____ESL: _____

School: _____Nurse: _____

Preschool: _____Frequency: _____

HEALTH HISTORY

I. FAMILY HISTORY: (Parents/Grandparents/Siblings: Hx Heart Disease, HTN, Diabetes, Cancer, Asthma, Allergies: Food/Environmental/Medication/Insect Stings or Bites, Seizures, Lyme Disease etc)

II. ILLNESSES/OPERATIONS:

Does your child get sick frequently? _____
Frequent Sore Throats? _____
Bronchitis or Asthma? _____
Medications needed at school? _____
Has your child been hospitalized? _____Dates of hospitalization? _____
_____
ER Visits/Dates: (stitches/ broken bones/ accidents etc.) _____
_____
History of Lyme Disease/Date: _____Treatment: _____
History of Tick Bite: _____Date: _____Reaction: _____
Current Medications for Any Reason: _____
Does your child have a chronic health condition? _____
Treatment/Intervention: _____

III. ALLERGIES/SENSITIVITIES:

Food: (specify)_____
Reaction: _____
Allergy Action Plan: _____
Environmental: (specify)_____
Reaction: _____
Allergy Action Plan: _____
Medications: (specify)_____
Reaction: _____
Penicillin_____ Sulfa_____
Insect Stings/Bites: (specify)_____
Reaction: _____
Allergy Action Plan? _____
Allergies Verified by Allergist: _____Yes _____No

Is your Child aware of his/her allergy? _____ Level of child's knowledge? _____
Any Special Concerns? _____
Vision or Hearing Concerns? _____

_____ _____
Parent Name **Date** **Nurse Name** **Date**

Revised: 11/13