

Medical History

Pre-School and Kindergarten

Date: _____

Last Name: _____ First: _____ Middle: _____

DOB: _____ Grade: _____ Male: _____ Female: _____

Address: _____

Phone: _____ Cell Phone: _____

Mother's Name: _____ Father's Name: _____

Sibling: _____ Age: _____ Grade: _____

Sibling: _____ Age: _____ Grade: _____

Sibling: _____ Age: _____ Grade: _____

This student is _____ in the family.
(number)

1. With whom does this child live? _____
2. When did your child last have a physical exam or visit to M.D.? _____
(Date)
3. When did your child have a dental exam? _____
(Date)
4. Has your child had any accidents/operations since birth? (circle one) YES NO
5. Has your child had any of the following? Please check yes or no. Provide date and comment if needed.

	Yes	No		Yes	No
Frequent Colds			Mumps		
Frequent Stomachaches			Measles		
Frequent Headaches			Polio		
Strep Throat			Chicken Pox		
Rheumatic Fever			Epilepsy		
Scarlet Fever			Tuberculosis		
Bronchitis			Cancer		
Pneumonia			Heart Disease		
Seizures			Attention Deficit Disorder		
Anemia			Diabetes		
Whooping Cough			Other Illness		

Comments: _____

6. Does your child have asthma? (circle one) YES NO
If yes, briefly describe frequency, symptoms and medication prescribed to be given at home or in school: _____
7. Does your child have an allergy to bee stings? (circle one) YES NO NEVER STUNG
If never stung, does any family member have severe reactions?
Describe: _____

If YES, please check type of reaction:

_____ Local swelling _____ Generalized swelling _____ Hives

Please describe treatment and medication to be given at school in case of bee sting reactions: _____

8. Does your child have environmental, food or medication allergies?

(circle one) YES NO

If yes, please specify: _____

Describe reaction: _____

Treatment or medication to be administered at school in case of reactions: _____

9. Does your child take medication daily? (circle one) YES NO

If yes, specify name and reason: _____

10. Does your child have any physical limitations or restrictions for activity?

(circle one) YES NO

If yes, explain: _____

11. Does your child have frequent ear infections? (circle one) YES NO

Has your child had a hearing test? (circle one) YES NO

If yes, Date: _____ Name of physician: _____

Results found: _____

Does your child have tubes in his/her ears? (circle one) YES NO

If yes, date(s) of insertion: _____

12. Does your child wear glasses? (circle one) YES NO

Date of last eye exam: _____ Name of physician: _____

Visual problems found: _____

Concerns: _____

13. Is bedwetting a problem? (circle one) YES NO

Does your child have wetting accidents during the day? (circle one) YES NO

Does your child have occasional accidents with bowel movements? (circle one) YES NO

If yes to either, specify time: _____

14. Birth weight: _____

15. Were there any complications before, during or immediately after birth?

(circle one) YES NO

If yes, explain: _____

16. What age did your child...walk alone? _____

Talk (Two words together)? _____ Daytime toilet trained? _____

17. Do any close relatives have a history of the following:

(Please X and indicate relationship to the child.

Diabetes _____ Cancer _____

High Blood Pressure _____ Anemia _____

Seizures _____ Sickle Cell Anemia _____

Learning Problems _____ Mental Retardation _____

Birth Defect _____ Heart Disease _____

Other _____

18. Are there any concerns within the child's living situation that may affect learning?

19. Please advise of any health (physical/socio-emotional) issues not previously addressed concerning your child?

Consistent with the Connecticut General Statute 10-104a, your child must have a physical examination, including a blood test for anemia, and mandated immunizations prior to school entry.

I understand that it is my responsibility to establish, with the physician of my choice, an appointment to complete a physical examination, including required immunizations, and to provide the school with this information before my child will be allowed to attend school.

Student's name: _____

Parent/Guardian Signature: _____

Date: _____

Health Department Use Only

Please check as each step is completed:

- Social/Medical History is obtained
- Physical exam form given to parent
- Physical exam form completed
- Verification of immunization
- Special needs care plan completed
- Vision and audio screening performed
- Emergency card completed

Student Name: _____

Grade: _____	Year: _____	Status: _____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____