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:
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____