

SCHOOL ENTRANCE HEALTH INFORMATION FORM

Name: _____ Student ID#: _____
Last First Middle Name

Birthdate: Mo. _____ Day _____ Year _____ Gender: Male _____ Female _____

Person to call in case of an emergency if parent/guardian is not available:

Name: _____ Phone: _____

Please provide information relative to the general health of your child entering school for the first time and return to principal within 15 days.

ACUTE OR CHRONIC ILLNESSES

_____ Yes _____ No Asthma
_____ Yes _____ No Cerebral Palsy
_____ Yes _____ No Cystic Fibrosis
_____ Yes _____ No Diabetic (Insulin dependent)
_____ Yes _____ No Epilepsy
_____ Yes _____ No Frequent colds
_____ Yes _____ No Frequent sore throat
_____ Yes _____ No Hyperthyroidism
_____ Yes _____ No Hypothyroidism
_____ Yes _____ No Allergies other than those related to food/drugs: if yes, describe _____
_____ Yes _____ No Cancer: if yes, describe _____
_____ Yes _____ No Heart disease: if yes, describe _____

ACCIDENTS

Has your child had any of the following? If yes, describe.

_____ Yes _____ No Burns requiring treatment _____
_____ Yes _____ No Bumps to head requiring treatment _____
_____ Yes _____ No Fractures _____
_____ Yes _____ No Lacerations or cuts requiring stitches or tetanus booster _____
_____ Yes _____ No Near drowning _____
_____ Yes _____ No Poisoning _____
_____ Yes _____ No Serious falls _____

MEDICATIONS

Is your child using any medicines? If yes, describe.

_____ Yes _____ No Prescription drugs: identify drug and condition requiring drug _____
_____ Yes _____ No Over-the-counter drugs (nonprescription): identify drug and reason for use _____
_____ Yes _____ No Drug allergies: identify drug and reaction _____

NUTRITION

 Yes No **Abdominal pain**
 Yes No **Underweight or overweight for age**
 Yes No **Allergies related to foods: identify food and reaction** _____
_____ Yes _____ No **Problems with elimination (bowel movement and/or urination)** _____

OPERATIONS

 Yes No **Appendectomy**
 Yes No **Hernia**
 Yes No **Tonsillectomy**
 Yes No **Tubes in ear**
Other _____

ORTHOPEDIC CONDITION/DEVICES

 Yes No **Scoliosis**
 Yes No **Spina bifida**
Other _____
 Yes No **Wheelchair**
 Yes No **Special shoes**
 Yes No **Crutches**
 Yes No **Braces**
 Yes No **Helmet**

HEARING

 Yes No **Frequent ear aches**
 Yes No **Running ear**
 Yes No **Hard of hearing**
 Yes No **Uses hearing aid**

BLOOD DISORDERS

 Yes No **Anemia**
 Yes No **Leukemia**
 Yes No **Hemophilia**
 Yes No **Sickle Cell Anemia**

COMMUNICATION

 Yes No **Speech understandable**
 Yes No **Stutters/stammers**
 Yes No **Lisp**

HABITS

 Yes No **Sleeps/Rests well**
 Yes No **Exercises daily**
 Yes No **Eats well**
 Yes No **Bathes regularly**
 Yes No **Brushes teeth regularly**

DENTAL

 Yes No **Cavities**
 Yes No **Cleft lip or palate**
 Yes No **Gum disease**
 Yes No **Lost some or all baby teeth**
 Yes No **Permanent teeth appearing**
 Yes No **Wears dental braces**

VISION

 Yes No **Wears glasses**
 Yes No **Rubs eyes frequently**
 Yes No **Squints**
 Yes No **Color blind**

MENTAL AND EMOTIONAL

 Yes No **Bullies others**
 Yes No **Cries often**
 Yes No **Lethargic (slow/lazy)**
 Yes No **Short attention span**
 Yes No **Toilet trained**
 Yes No **Very sensitive**
 Yes No **Very shy**
 Yes No **Generally happy**

SKIN AND HAIR

 Yes No **Visible scars**
 Yes No **Hives**
 Yes No **Scabies**
 Yes No **Body lice**
 Yes No **Head lice**

Were there any prenatal or birth complications which affected the child? _____

Please indicate any other condition(s) your child has that is not covered on form. _____

Signed: _____ Date: _____
(Signature of Parent/Guardian) CS1,260/R06