Form #227 (NEW FORM NUMBER 07-08)

ARKANSAS STATE DEPARTMENT OF EDUCATION/HEALTH
HEALTH HISTORY
DEVELOPED BY A COMMITTEE OF THE ARKANSAS HEALTH CARE ACCESS COUNCIL

NOTE: To be completed by the parent/guardian of the Kindergarten student prior to the physical examination/nursing assessment (please print).

Student Name (Last, First, Middle)	Birth Date (MO./DAY/YR.) / / School	Medicaid Number Medicaid Physician

Parent/Guardian Name (Male) Phone	Parent/Guardian Name (Female) Phone

Physician Name and Address (If no regular physician, write "None") Phone

Dentist Name and Address (If no regular dentist, write "None") Phone

Other source(s) from which the student receives health care (If none, write "None") Phone

Name and address of private health insurance carrier:

To be completed by parent/guardian (please check one):

1.	Does your child pay attention when being read to?	Yes ☐	No ☐
2.	Can your child play quietly alone for over a ½ hour?	Yes ☐	No ☐
3.	Does your child mind adults and follow instructions?	Yes ☐	No ☐
4.	Does your child speak clearly enough for other to understand?	Yes ☐	No ☐
5.	Does your child have any speech problems (stammering, delayed	Yes ☐	No ☐
6.	Does your child object to being left with a sitter	Yes ☐	No ☐
7.	Can your child dress without help?	Yes ☐	No ☐
8.	Does your child ever wet or soil him/herself during the day	Yes ☐	No ☐
9.	Do you have any concerns about your child's general health (eating and sleeping habits, bowel or bladder, posture, teeth, skin, weight, etc.)?	Yes ☐	No ☐

10. Does your child have any eye problems (difficulty seeing, crossed eyes, frequently reddened or watery eyes, wear glasses or contact lenses)?	Yes ☐	No ☐
11. Does your child have any ear or hearing problems (frequent earaches, difficulty hearing, draining ear, use a hearing aid, etc.)?	Yes ☐	No ☐
12. Does your child have any allergies (foods, insects, drugs, pollens, etc.)?	Yes ☐	No ☐
13. Does your child have any specific sickness which might in your opinion affect his school performance or program?	Yes ☐	No ☐
a) Has your child received any medical or other evaluation, the findings of which could help school personnel in meeting his/her health or educational needs?	Yes ☐	No ☐
b) Does this problem require any health care in the school?	Yes ☐	No ☐
c) Does your child take medications?	Yes ☐	No ☐
14. Do you have any concerns about your child's developmental behavior or emotional well being of which the school should be aware?	Yes ☐	No ☐

If you answered YES to any of the preceding questions, please describe the problem or concern you have below:

Question Number	Description
1	
1	
1	
1	
1	

Information on this form may be shared with appropriate personnel for health and educational purposes.

Parent's Signature_____ Date_____