# *Sterling Community School*
# *Preschool / Kindergarten Health Information*

Child's Name: _____ Date of birth: _____

Address: _____Daytime # _____

Grade/Teacher: _____ Emergency # _____

1. Does your child have health insurance? __ Yes __ No Insurance company/ policy number_____
2. When was your child's last physical exam? _____
3. When was your child's last dental exam? _____
4. Has your child had any accidents or operations since birth? ____ Yes ____ No

If yes, please explain and include dates : _____

5. Has your child had any of the following: Please check yes or no, give date and comment if needed.

| | Date | Yes | No | | Date | Yes | No |
|---|---|---|---|---|---|---|---|
| Frequent colds | _____ | _____ | ____ | Mumps | _____ | _____ | ____ |
| Frequent stomach aches | _____ | _____ | ____ | Measles | _____ | _____ | ____ |
| Frequent headaches | _____ | _____ | ____ | Strep throat | _____ | _____ | ____ |
| Frequent ear infections | _____ | _____ | ____ | Polio | _____ | _____ | ____ |
| Rheumatic fever | _____ | _____ | ____ | Chicken Pox | _____ | _____ | ____ |
| Scarlet fever | _____ | _____ | ____ | Epilepsy | _____ | _____ | ____ |
| Bronchitis | _____ | _____ | ____ | Tuberculosis | _____ | _____ | ____ |
| Pneumonia | _____ | _____ | ____ | Cancer | _____ | _____ | ____ |
| Seizures | _____ | _____ | ____ | Heart Disease | _____ | _____ | ____ |
| Attention Deficit Disorder | _____ | _____ | ____ | Anemia | _____ | _____ | ____ |
| Diabetes | _____ | _____ | ____ | Whooping Cough | _____ | _____ | ____ |
| Other illness | _____ | _____ | ____ | | | | |

Comments:

_____

_____

6. Does your child have Asthma? Yes _____ No _____ If yes: describe frequency, symptoms and medication prescribed given at home or in school. _____
7. Does your child have an allergy to Bee Sting? ___Yes ___No Never stung____

Describe reaction/Treatment _____

8. Does your child take any medication daily? ____ Yes ____ No

Specify name and reason: _____

9. Does your child have any environmental, food or medication allergies? ___Yes ___ No

Specify: _____

Describe reaction: _____

Treatment: _____

10. Tell me about your child's appetite:

_____

_____

_____

11. Does your child feed him/herself? ❑ Yes ❑ No If yes, please describe: (Fork, Spoon, Fingers)_____

12. Are there any foods that your child should not eat for religious or personal reasons? ❑ Yes ❑ No
If yes, what? _____

13. Is your child on any special diet? ❑ Yes ❑ No If yes, please describe: .

_____

_____

14. Does your child eat or chew things that are not food? ❑ Yes ❑ No If yes, what?

_____

_____

_____

**How many times a day does your child eat?**

- Milk, cheese, yogurt 0 1 2 3 4 +
- Meat, poultry, fish, eggs, peanut butter, dried peas/beans 0 1 2 3 4 +
- Bread, cereal, rice, grits, tortillas, cracker, muffins, bagels 0 1 2 3 4 +
- Fruits and vegetables (including 100% juice) 0 1 2 3 4 +
- Oil, butter, margarine, lard, fried foods 0 1 2 3 4 +
- Cookies, cakes, candy, gum, sodas, fruit drinks (like Kool-Aid) 0 1 2 3 4 +

*Fruits and vegetables that are dark green, red & orange are high in vitamin C and A. These are important for children's growth and development. That is why we ask about those specific fruits and vegetables.

**How many times a week does your child eat?***

- Carrots, broccoli, greens, winter squash, sweet potato 0 1 2 3 4 5 6 7 +
- Tomatoes, oranges, grapefruits (fruit, sauce or juice) 0 1 2 3 4 5 6 7 +

15. Does your child have any physical limitations or restrictions for activity:
Yes ____ No ____ Explain: _____

16. Has your child had a hearing test? Yes _____ No ____ Date: _____

Name of M.D. _____

Result found _____

Does your child have tubes in his / her ears? Yes ____ No ____

Date of insertion: _____

17. Does your child wear glasses? Yes ____ No ___ Date of last eye exam _____

Name of Doctor _____ Visual problem found: _____

Concerns: _____

18. **Please provide a complete copy of your child's immunization record.**

_____ _____

Parent/Guardian Signature Date