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_____

Student Name: _____ Date of Birth: _____

KINDERGARTEN PHYSICAL ASSESSMENT

To be Completed by Physician, APN, or other Health Professional

REQUIRED

	NL	ABNL	Comments
B/P:_____ WT:_____HT:_____			
SKIN: Color, Rash, Swelling, Hair, Nails			
EYES: Conjunctiva, Cornea, Pupils, Extraocular Movement.			
EARS: Pinnae, Canals, Tympanic Membrane, Appearance, Mobility			
NOSE: Nares, Turbinates			
MOUTH: Tongue, Teeth, Oral Mucosa, Tonsils, Pharynx			
NECK: Thyroid, Range of Motion			
NODES: Cervical, Axilary, Inguinal, Other			
HEART: Rate, Rhythm, S1, S2, Murmur, Femoral Pulses			
LUNGS: Rate, Auscultation, Percussion			
ABDOMEN: Contour, Palpation of liver, Spleen, Kidneys, Mass: Tenderness			
GENITO-URINARY: Female external, Male Penis, Meatus, Testes, Hernia			
MUSCULOSKELETAL: Range of Motion, Tenderness, Edema, Clubbing Spine (Curvature).			
NEUROLOGICAL: Gait, Cerebullar Function, Motor System (Strength, Tone): Cranial Nerves (Gross)			
DEVELOPMENTAL			
Gross Motor			
Fine Motor			
Social			
Speech/Language			

SUPPLEMENTAL (optional)

	Date	NL	Comments
Hemoglobin			
Hematocrit			
Urinalysis			
Other			

Medications_____

_____

_____

Diet Restrictions_____

_____

_____

Special Equipment_____

_____

_____

Allergies_____

_____

_____

General comments/Recommendations_____

_____

_____

_____

_____

_____

_____

I have performed a physical assessment on this child on the date indicated, and have arranged for any follow-up that was or is needed.

Signature_____Phone_____Date Signed_____Date of Exam_____

Physician, APN, or other Health Professional