"You cannot educate a child who is not healthy, and you cannot keep a child healthy who is not educated."

JEB-R

Lin-Wood Public Schools
72 Linwood Drive
Lincoln, NH 03251

Kindergarten Health Information

Dear Parent,

We would like your child to gain the most benefit from his/her school experience. In order for us to assist in accomplishing this task, it is necessary to have a current health history from a parent's perspective. Please complete this form and return it to the nurse as soon as possible. This information is considered confidential and will be shared with professional personnel only as necessary for your child's safety or in planning an educational program.

Child's name _____ Birth date _____
Name child likes to be called _____ (circle) M F

Family Info

Child lives with: ☐parents ☐mom ☐dad ☐foster family ☐guardian

Mom's Name_____ Dad's Name _____
Address _____ Address _____
Phone_____ Phone _____
Workplace _____ Phone_____ Workplace_____ Phone_____

Siblings: Name DOB School Attending

_____ _____ _____
_____ _____ _____
_____ _____ _____

Others in the home:_____

After school my child goes: _____Home
_____Childcare Provider Name _____
Phone # _____
_____ Not known at this time/Will notify you

Doctor's name _____ Phone _____

Medical Information

Does your child have any **allergies** to foods, medications, insect/bee stings, latex, etc.? (circle) YES / NO
If so, what symptoms does he/she exhibit? _____
What treatment is necessary? _____
If your child takes daily **medication** at home:
Name of med/dosage/reason_____
If your child takes daily medication at school:
Name of med/dosage/time/reason _____
Has your child had any operations, serious accidents or illnesses? (circle) YES / NO
Please explain _____
_____
Please describe anything unusual about the pregnancy/delivery of this child?
_____
Birth weight _____
Describe any special medical care your child required during he first few months after birth.
_____

Does your child have any **special health conditions**?
Asthma____ Diabetes____ Epilepsy/seizures____ Heart____ Injury____
Cancer____ Vision____ Hearing____ Kidney____ Other_____

Please explain, including any need for special attention or limitations of activities:

_____

_____

Has your child had any of the following **health concerns**?

frequent nosebleeds____	dry skin/eczema____	ear infections____
frequent headaches____	overweight____	bronchitis____
frequent stomach aches___	constipation____	anemia____ colds____
frequent sore throats____	tonsillitis____	frequent strep throats____
high lead level ____	bedwetting____	daytime wetting/soiling____

Has your child had **chicken pox**? (circle) YES / NO Varicella immunization_____

Does your child have **health insurance**? (circle) YES / NO If no, check below if you would like information about the NH Healthy Kids Insurance Program? ☐

Describe anything more about your child's health that you think is important for us to know?

_____

_____

List any school activities that your child can not participate in and explain.

_____

Social Development

Does your child:	Yes	No
Have regular playmates the same age?	___	___
Have difficulty getting along with others?	___	___
Prefer to play with others instead of alone?	___	___
Become easily frustrated?	___	___
Cry often?	___	___
Have a bad temper?	___	___
Enjoy cooperating with others?	___	___
Become frequently irritated or moody?	___	___
Become upset by changes in routine?	___	___
Have difficulty separating from you?	___	___
Have difficulty dealing with family stress such as illness, death, or separation?	___	___
Demand much individual adult attention?	___	___
Accept discipline and limits?	___	___
Know how to read?	___	___
Know how to write?	___	___

Has your child attended pre-school or day care? (circle) YES / NO

If yes, where?_____ How long? _____

If your child has ever received any Special Services, please explain. _____

_____

Please give us any additional information you feel would be helpful to us to assist your child in making a successful transition into school and providing the best opportunities for reaching his/her academic and social potential.

_____

_____

What are your expectations for the kindergarten program? What specific things would you like to see happen this year?

_____

Would you like an individual conference with the **nurse** or **guidance counselor** to relate any information you don't feel comfortable writing on this form? (circle which one)

Developmental History

Which hand does your child usually use? (circle) RIGHT LEFT Not sure
At what age did your child begin to crawl? _____ walk? _____
At what age was toilet training completed? _____
Does your child use the bathroom independently? _____

What **skills** has your child acquired?

_____ can say his/her full name _____ dresses himself/herself
_____ can say address _____ can button and/or snap
_____ knows phone number _____ uses a zipper
_____ knows birthday _____ ties shoes
_____ can tell time _____ puts on boots
_____ can print full name _____can name colors
_____ can use crayons _____ can use scissors
_____ can draw a circle ____square ____triangle ____rectangle
_____ can recognize numbers to 12 _____ counts to (how far?)
_____ recognizes lowercase letters _____ recognizes Capital letters
_____ recognizes letter sounds _____ says ABCs
_____ can follow more than one direction at a time
_____ stays with a task for 5 minutes or more
_____ usually speaks in full sentences
_____ if reading, how did he/she learn? _____ for how long?

Does your child seem to have any difficulty with fine motor activities,
such as writing, coloring, etc.? (circle) YES / NO/ ?
Does your child have any difficulty with gross motor skills, such as
skipping, hopping, running, etc.? (circle) YES / NO/ ?
Does your child's activity level seem appropriate for his/her age? (circle) YES / NO
What special interest does your child have? _____
Is your child especially fearful of anything? _____
At what age did this child begin to speak, approximately? _____
Does he/she stutter or have difficulty expressing ideas? (circle) YES / NO
Does his/her vocabulary seem appropriate for age? (circle) YES / NO/ ?
Has your child ever had a formal speech and language assessment? If yes, when and by whom
_____
Do you suspect your child may have a hearing or vision problem? (circle) YES / NO/ ?
If yes, please explain. _____
Has your child ever had a developmental or psychological evaluation?
(circle) YES / NO/ ? If yes, when and by whom?_____

Thank you for your patience in completing this questionnaire.

See Policy JEB
Reviewed: July 22, 2014
