

School Entrance Health Information Form

Name: _____ Birthdate: Mo. _____ Day _____ Yr. _____

Sex: Male Female Race: _____ Child's Social Security Number: _____

Parent or Guardian: _____ Work Number: _____
Last First Middle Home Number: _____

Home Address: _____
Street City State Zip

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 the 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 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 Fall _____

MEDICATIONS

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

- Yes No Prescription drugs: Identify drugs and condition requiring drugs. _____
- 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 Other _____

HANDICAPPING CONDITIONS

- Yes No Scoliosis
- Yes No Spina Bifida
- Yes No Other _____

ORTHOPEDIC DEVICES

- Yes No Wheelchair
- Yes No Special Shoes
- Yes No Crutches
- Yes No Braces
- Yes No Helmet

HEARING

- Yes No Frequent Earaches
- Yes No Running Ear
- Yes No Hard of Hearing
- Yes No Uses Hearing Aids

COMMUNICATION

- Yes No Speech Understandable
- Yes No Stutters/Stammers
- Yes No Lisps

DENTAL

- Yes No Cavities
- Yes No Cleft Lip or Palate
- Yes No Gum Disease
- Yes No Lost all or some baby teeth
- Yes No Permanent teeth appearing
- Yes No Wears dental braces

MENTAL & 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

BLOOD DISORDERS

- Yes No Anemia
- Yes No Leukemia
- Yes No Hemophilia
- Yes No Sickle cell anemia

HABITS

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

VISION

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

SKIN & 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 health condition(s) your child has that is not covered on form _____

Signature: _____ Date: _____
(Signature of Parent/Guardian)