Dubuque COMMUNITY SCHOOLS

PRESCHOOL / KINDERGARTEN MEDICAL HISTORY QUESTIONNAIRE

STUDENT INFORMATION

STUDENT NAME:	DATE OF BIRTH (mm/dd/yyyy):	PARENT / GUARDIAN NAME(S):
STUDENT LIVES WITH: [ ] both parents [ ] mother [ ] father [ ] other *If other, please explain:*		PARENTS ARE: [ ] married [ ] divorced [ ] separated
AGE OF PARENTS AT BIRTH OF STUDENT: mother father	HIGHEST LEVEL OF EDUCATION OF PARENTS AT BIRTH OF STUDENT: mother father	
STUDENT'S BIRTH WEIGHT:	PREMATURE: [ ] YES [ ] NO *If yes, gestational age at birth:*	SIBLINGS: total number number older number younger
DOCTOR NAME:	DATE OF LAST EXAM:	MEDICAL INSURANCE: [ ] PRIVATE [ ] MEDICAID / TITLE 19 [ ] HAWK I [ ] NONE / HOSPITAL PREFERENCE:
DENTIST NAME:	DATE OF LAST EXAM:	DENTAL INSURANCE: [ ] PRIVATE [ ] MEDICAID / TITLE 10 [ ] HAWK I [ ] NONE

PLEASE ANSWER THE QUESTIONS BELOW

IS YOUR CHILD UNUSUALLY SHY, QUIET, OR SENSITIVE? [ ] YES [ ] NO *If yes, please explain:*

DOES YOUR CHILD CRY EASILY, BECOME OVERACTIVE, OR HAVE TEMPER TANTRUMS? [ ] YES [ ] NO *If yes, please explain:*

PLEASE CHECK the appropriate box for each question and provide additional details when applicable.

DK=Don't Know

DO THESE APPLY TO YOUR CHILD?	YES	NO	DK	ADDITIONAL DETAILS:
ATTEND PRESCHOOL/DAYCARE	[ ]	[ ]	[ ]	*If yes, school:*
EYE PROBLEMS	[ ]	[ ]	[ ]	*Please explain:*
EYE/VISION EXAM	[ ]	[ ]	[ ]	*If yes, doctor:* *Date of exam:*
WEAR EYE GLASSES	[ ]	[ ]	[ ]	*If yes, worn for:* [ ] close up [ ] far away
EAR PROBLEMS	[ ]	[ ]	[ ]	*Please explain:*
TUBES PLACED IN EARS	[ ]	[ ]	[ ]	*If yes, date of procedure:* *Are they still in place?* [ ] YES [ ] NO
TEETH PROBLEMS	[ ]	[ ]	[ ]	*Please explain:*
SPEECH PROBLEMS	[ ]	[ ]	[ ]	*Please explain:*
RECEIVE SPEECH SERVICES	[ ]	[ ]	[ ]	*Please explain:*
HEART PROBLEMS	[ ]	[ ]	[ ]	*Please explain:*
HEART SURGERY	[ ]	[ ]	[ ]	*If yes, surgery:* *Date of surgery:*
SEIZURES	[ ]	[ ]	[ ]	*Date of last seizure:*
TAKE SEIZURE MEDICATION	[ ]	[ ]	[ ]	*If yes, name of medication:* *Needed at school?* [ ] YES [ ] NO

» PLEASE COMPLETE BOTH SIDES

NOTE: If you wish to save data typed into this form, first save the file on your computer and re-open from your computer prior to typing.

continued

DK=Don't Know

DO THESE APPLY TO YOUR CHILD?	YES	NO	DK	ADDITIONAL DETAILS:	
ASTHMA	[ ]	[ ]	[ ]	*If yes, type:*	
TAKE ASTHMA MEDICATION	[ ]	[ ]	[ ]	*If yes, name of medication:*	*Needed at school?* [ ] YES [ ] NO
EATING PROBLEMS	[ ]	[ ]	[ ]	*Please explain:*	
ALLERGIES	[ ]	[ ]	[ ]	*If yes, list allergies*:	
TAKE ALLERGY MEDICATION	[ ]	[ ]	[ ]	*If yes, name of medication:*	*Needed at school?* [ ] YES [ ] NO
LIST ALLERGY SYMPTOMS (cough, rash, wheeze, etc.):					
BLADDER / BOWEL PROBLEMS	[ ]	[ ]	[ ]	*Please explain:*	
TOILET INDEPENDENTLY	[ ]	[ ]	[ ]	*Please explain:*	
OTHER HEALTH CONCERNS	[ ]	[ ]	[ ]	*Please explain:*	
SERIOUS INJURIES	[ ]	[ ]	[ ]	*Please explain:*	
PAST / FUTURE SURGERIES	[ ]	[ ]	[ ]	*Please explain:*	
CHICKENPOX	[ ]	[ ]	[ ]	*If yes, date of illness (month/year):*	
ORTHOPEDIC CONCERNS	[ ]	[ ]	[ ]	*Please explain:*	
EVALUATED BY KEYSTONE	[ ]	[ ]	[ ]	*Please explain:*	

PLEASE SIGN BELOW

I agree that this information may be released to school personnel who need to know.

_____ _____

PARENT / GUARDIAN SIGNATURE DATE

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