New Prague Area Schools **Kindergarten Health History**

Student Name ____ **Date of Birth** ______________________

☐ **Male** ☐ **Female**

Student's last physical ___________**Date** ___________**Clinic** ______________**Physician**_____________

In order to better maintain your child's health & safety, please check any or all areas of concern:

- ☐ **Asthma**
- ☐ **Allergies**
  - ☐ **Bee sting (mild or severe)**
  - ☐ **Food** __________________
  - ☐ **Hayfever/Seasonal**
- ☐ **Diabetes**
- ☐ **Emotional/Behavioral**
  - ☐ **ADD(H)**
  - ☐ **Anxiety**
  - ☐ **Depression**
  - ☐ **Other**_____________
- ☐ **Epilepsy/Seizures**
- ☐ **Headaches**
  - ☐ **Treated with** ____________
- ☐ **Hearing concerns**
  - ☐ **Wears hearing aid (L R)**
  - ☐ **Earaches**
  - ☐ **Loss of hearing (L R)**
- ☐ **Injury/Trauma**
  - ☐ **Head**
  - ☐ **Other** _________
- ☐ **Heart Condition**
  - ☐ **Dizziness/Fainting**
  - ☐ **Other**
- ☐ **Nosebleeds** ___ **frequent**
- ☐ **Sinus Infections** ___ **frequent**
- ☐ **Sore throats/colds** ___ **frequent**
- ☐ **Vision Concerns**
  - ☐ **Wears glasses**
  - ☐ **Wears contacts**
  - ☐ **Other** __________
- ☐ **Stomach concerns**
  - ☐ **Stomachaches**
  - ☐ **Ulcers**
  - ☐ **Other**
- ☐ **Weight concern**
  - ☐ **Gain**
  - ☐ **Loss**
- ☐ **Other Health Issues**
  - ☐ _________________________
  - _________________________
  - _________________________

Any complications during pregnancy, labor or delivery? ☐ **yes** ☐ **no**

Explain____

Any hospitalization since birth? ☐ **yes** ☐ **no** **date**___________________________________

Explain ____

Is your child on medication? ☐ **yes** ☐ **no** **Name of medications** ______________________________

***The Medication Administration Form needs to be completed for all medication given at school.**

Are there any toileting concerns (day/night wetting/frequency/urgency) ☐ **yes** ☐ **no**

Explain ____

Are there any health issues school/staff need to know ☐ **yes** ☐ **no** ___________________________

____

Are there problems or concerns at home that may affect your child's learning? ___________________

____

I understand that the information provided above will be shared in a confidential manner with appropriate staff members who need to know in order to provide for the health and safety of my student. I will keep the school informed of any changes in health status or contact information. Information provided on this form is true and accurate. This information may also be shared with summer school staff when appropriate.

____ _________________________

Parent/Guardian Signature **Date**