# School Entrance Health Information Form

Name: ________________________________________ Birthdate: Mo. ______ Day ______ Yr. ______
Last First Middle Sex:

☐ Male ☐ Female Race: ________________

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)