BLACK ROCK ELEMENTARY SCHOOL
PRE-SCHOOL AND KINDERGARTEN
HEALTH QUESTIONNAIRE

Date: _____ (Grade: _____ School Year: _____

Child's Legal Name: _____ Birth Date: _____ Sex: _____
Address: _____ Phone: (_____)_____
Mother's Name: _____ Father's Name: _____
Child lives primarily with (please circle): Both Parents Mother Father Other
If other: Name _____ Relationship_____

Brothers/sisters	Birthdates	School	Brothers/sisters	Birthdates	School

Do the brothers and sisters reside with the child? Yes _____ No _____

Primary Physician: _____Phone: (_____)_____
Dentist: _____ Phone: (_____)_____
Eye Doctor: _____Phone: (_____)_____
Hospital Preferred: _____

MEDICAL HISTORY OF CHILD

Has your child had:	*YES	NO
1. ADHD/ADD	_____	_____
2. Allergy to (please specify & state reaction):		
Food	_____	_____
Medication	_____	_____
Insect	_____	_____
Seasonal	_____	_____
Other	_____	_____
EpiPen required?	_____	_____
3. Any difficulty with hearing, vision, speech	_____	_____
-Wears glasses (if yes, circle below)	_____	_____
(distance, reading, full-time)		
-Wears hearing aide	_____	_____

	*YES	NO
4. Anemia	_____	_____
5. Asthma	_____	_____
6. Cerebral Palsy	_____	_____
7. Diabetes	_____	_____
8. Elevated Lead Levels	_____	_____
9. Frequent Ear Infections	_____	_____
10. Heart Problems	_____	_____
11. Hospitalizations	_____	_____
12. Operations	_____	_____
13. Seizures	_____	_____
14. Severe Injuries	_____	_____
15. Other Medical Issues *(Please specify)*	_____	_____

*If yes to any of the above, please explain below:

_____
_____
_____

For School use only: _____
_____
_____

(See Reverse Side)

Child's Legal Name: _____ Birth Date: _____

PREGNANCY HISTORY

During this pregnancy did you have:		Please Comment
Anemia	_____ Yes _____ No	_____
Elevated Blood Pressure	_____ Yes _____ No	_____
Toxemia	_____ Yes _____ No	_____
Measles	_____ Yes _____ No	_____
German Measles/ Rubella	_____ Yes _____ No	_____
Injury/Illness	_____ Yes _____ No	_____
Threatened Miscarriage	_____ Yes _____ No	_____
Medication During Pregnancy	_____ Yes _____ No	_____
Abnormal Tests During Pregnancy	_____ Yes _____ No	_____

BIRTH HISTORY

Did you have prenatal care? Yes _____ No _____

How long was your labor? _____

Was the baby premature? Yes _____ No _____ How many months? _____

Baby's weight at birth: _____ lbs. _____ oz.

Was the baby's color normal? Yes _____ No _____ Blue _____ Yellow _____

Did the baby have breathing problems? Yes _____ No _____

Cord around the neck? Yes _____ No _____

Was oxygen used for the baby? Yes _____ No _____

Was delivery unusual in any way? Yes _____ No _____ How? _____

Was the newborn exam unusual? Yes _____ No _____

If yes to above, please comment.

_____

_____

_____

_____

DEVELOPMENTAL HISTORY

How old was your baby when he/she (please check):

Milestones	0-3 Mos.	4-8 Mos.	9-12 Mos.	13-18 Mos.	19-24 Mos.	2-3 Yrs.	4-5 Yrs.	Unknown
SAT UP								
SAID "MaMa/DaDa"								
WALKED								
USED SHORT SENTENCES								
HAD BLADDER CONTROL								
HAD BOWEL CONTROL								

I have been informed of the necessary requirements (i.e. health assessments, immunizations) for my child to begin/remain in school. I give permission for release of information on this form for confidential use in meeting my child's health and educational needs in school, including sharing health information with the bus company.

Parent Signature: _____ Date: _____