



To Parent/Guardian: Please complete and sign Part I – Child’s Medical History.

(Please Print)

Name of Child (Last, First, Middle)		Birth Date	Sex
Address (Street)		City and State	Zip
Home Telephone	Cell Phone	Parent/Guardian (Last, First, Middle)	

PART I – CHILD’S MEDICAL HISTORY

To Parent/Guardian: Please check answers to questions 1-7 below in the column on the left. Please explain any ‘Yes’ answers in the space provided below.

1. Yes No Any concerns about general health (eating and sleeping habits, weight, etc.)?
2. Yes No Any other specific illness or social/emotional or behavioral problems?
3. Yes No Any allergies (food, insects, medication, etc.)?
4. Yes No Any prescription medication (daily or occasionally)?
5. Yes No Any problems with vision, hearing, or speech (glasses, contacts, ear tubes, hearing aids)?
6. Yes No Any hospitalization, operation, or major illness (specify problem)?
7. Yes No Any significant injury or accident (specify problem)?

To Parent/Guardian: Please explain any ‘Yes’ answers from above.

I am the parent/guardian of the child named above. I give permission for the information on PARTS I and II of this form provided about my child to be reviewed and utilized only by the staff of this school for the limited purposes of meeting my child’s health and educational needs.

Signature of Parent/Guardian

Date

Partnership for School Readiness Recommendations for Prekindergarten and Kindergarten

To Parent/Guardian: Please obtain the services listed below in order to find any problems. Please work with your health care provider to correct or treat any problems that may reduce your child’s ability to learn in school. **(These services are recommended, but not required.)**

1. Vision Evaluation by optometry if suggested by primary care physician, or if you have concerns about your child’s eyes Date of Exam: _____ Results of Exam: _____ _____ Health Care Provider: _____ (check one) Optometrist <input type="checkbox"/> Ophthalmologist <input type="checkbox"/>	Please describe any corrective action for any problems detected and any accommodations required.
2. Comprehensive Dental Examination & Cleaning Date of Exam: _____ Results of Exam: _____ _____ Dentist: _____	Please describe any corrective action for any problems detected and any accommodations required.

