

**KINDERGARTEN STUDENT HEALTH HISTORY
IOWA CITY COMMUNITY SCHOOL DISTRICT**

TO PARENTS:

A pre-kindergarten health examination by your child's primary health care provider is important to your child's health and important for the school to be able to adapt its program to individual needs. Please have your child examined before entering school and periodically thereafter according to the recommendations of your child's primary health care provider and the school district. Please fill out this side of the form. Have your child's primary health care provider complete the back side of the form when your child is examined. Return the form to school at the beginning of the school year.

THIS SIDE TO BE COMPLETED BY PARENT:

_____/_____/_____
Child's Last Name Child's First Name Address Birthdate

Child's Physician/ NP/ PA Phone Hospital Preference

Does your child have any of the following, or does he/she have a history of any of the following? If answer is yes, please explain in detail below:

- | | YES | NO | |
|-----|-----|-----|---|
| 1. | ___ | ___ | Asthma |
| 2. | ___ | ___ | Seizures |
| 3. | ___ | ___ | Diabetes |
| 4. | ___ | ___ | Heart problems |
| 5. | ___ | ___ | Depression/Anxiety |
| 6. | ___ | ___ | ADD/ADHD |
| 7. | ___ | ___ | Allergies to food, medication, bee stings, dust/pollen |
| 8. | ___ | ___ | Headaches |
| 9. | ___ | ___ | Vision problems wears glasses_____ wears contacts_____ |
| 10. | ___ | ___ | Hearing problems left ear_____ right ear_____ hearing aid(s)_____ |
| 11. | ___ | ___ | Eating problems/dietary considerations |
| 12. | ___ | ___ | Bowel/bladder problem |

Details of health condition(s) to which you answered "yes" above

**IT IS THE PARENT'S RESPONSIBILITY TO PROVIDE A COMPLETED IMMUNIZATION CERTIFICATE FOR EACH CHILD
UPON ENTRY INTO SCHOOL!**

**KINDERGARTEN STUDENT HEALTH STATUS
IOWA CITY COMMUNITY SCHOOL DISTRICT**

NAME _____ BIRTHDATE____/____/____ DATE OF EXAMINATION____/____/____

THIS SIDE TO BE COMPLETED BY PHYSICIAN, NURSE PRACTITIONER, or PHYSICIAN ASSISTANT:

I hereby certify that the above named child was examined by me within the past twelve months and is able to participate in the school program of the Iowa City Community School District. YES [] NO []

Height_____ Weight_____ Blood Pressure_____ Vision_____ Hearing_____

CONCERNS/ RESTRICTIONS:

<p>1. Does this child have any vision, hearing, or speech concerns that the school should be aware of and/or make accommodations for? YES [<input type="checkbox"/>] NO [<input type="checkbox"/>] Needs further evaluation? YES [<input type="checkbox"/>] NO [<input type="checkbox"/>]</p>	<p>If yes or further evaluation is needed, please describe:</p>
<p>2. Does this child have any condition which may affect the child's participation in Classroom activities? YES [<input type="checkbox"/>] NO [<input type="checkbox"/>] Physical education/physical activities? YES [<input type="checkbox"/>] NO [<input type="checkbox"/>]</p>	<p>If yes, please describe:</p>
<p>3. Does this child have any condition which may result in a classroom emergency, i.e. asthma, seizures, fainting, diabetes, etc. ? YES [<input type="checkbox"/>] NO [<input type="checkbox"/>]</p>	<p>If yes, please describe:</p>
<p>4. Is there any emotional, mental, or physical condition for which this child should remain under periodic medical observation? YES [<input type="checkbox"/>] NO [<input type="checkbox"/>] Needs further evaluation? YES [<input type="checkbox"/>] NO [<input type="checkbox"/>]</p>	<p>If yes or further evaluation is needed, please describe:</p>
<p>5. Are immunizations up to date? YES [<input type="checkbox"/>] NO [<input type="checkbox"/>]</p>	<p>If no, please identify missing immunizations and plans for bringing up to date:</p>
<p>6. Has this child received a blood lead screening test, as required by Iowa law? YES [<input type="checkbox"/>] NO [<input type="checkbox"/>]</p>	<p>If so, please give the date and result of the lead screening, and plan for follow up if needed:</p>

Physician, NP, or PA Name (Printed)

Phone

Physician, NP, or PA Signature

Today's Date