REMSEN CENTRAL SCHOOL

PRE-K AND KINDERGARTEN HEALTH/SCREENING INFORMATION

Student's full name: _____ Gender: ☐ Male ☐ Female
Birthplace: _____ Date of birth: _____
911 Street Address: _____
Mailing Address: _____
Home phone: _____ e-mail address: _____

Father's Name: _____ Work/cell phone: _____
Mother's Name: _____ Work/cell phone: _____

Sibling name/s: _____ Age: _____ Grade: _____
_____ Age: _____ Grade: _____
_____ Age: _____ Grade: _____
_____ Age: _____ Grade: _____

Other household members and relationship to child:
_____ _____
_____ _____

In case of an emergency, I authorize the school to call:

PHYSICIAN: _____ Phone: _____
DENTIST: _____ Phone: _____
HOSPITAL PREFERENCE: _____ Phone: _____

Have your ever had any concerns about your child's motor skills, vision, speech or hearing? _____
If yes, please explain.

Has your child ever been referred or evaluated for occupational/physical therapy, vision, hearing or speech problems? _____ If yes, where? _____ When? _____
Results?

Does your child wear glasses? _____ How much of the time? _____
Why?

Is your child under the care of a physician for a specific health problem? _____ If yes, please explain.

Are there any limitations or restrictions? _____ If yes, please explain.

Does your child use any special equipment or braces? _____ If yes, please explain.

Date of last physical _____
Date of last dental exam _____ Results _____

Is your child currently on medication? _____ If yes, name of medication/s_____
Reason for medication.

Does your child have any known or suspected allergies to pets, food, drugs, or insects? _____
If yes, please list.

(please turn over)

Were there any complications during pregnancy and/or delivery? _____ If yes, please explain.

Was your child delivered at full term? _____ If no, how premature? _____

Did your child have any medical problems at birth or during the first few months of life? _____ If yes, please explain.

When did your child: _____ begin to walk _____ feed self
_____ say first word _____ say first sentence

Has your child had any of the following diseases or illnesses? Please give dates if the answer is yes.

_____ Chicken Pox	_____ Tuberculosis	_____ Frequent Colds
_____ German Measles	_____ Contact with TB	_____ Sore throats
_____ Mumps	_____ Scarlet Fever	_____ Frequent ear infections
_____ Measles	_____ Rheumatic Fever	_____ Pneumonia
_____ Diabetes	_____ Epilepsy	_____ High fevers
_____ Heart Disease	_____ Meningitis	_____ Asthma

Please explain complications below.

Has your child:

Had any other significant illness? _____ If yes, please explain.

Had a serious accident such as a head injury or broken bones? _____ If yes, please explain.

Ever been unconscious? _____ If yes, please explain.

Ever been hospitalized? When? _____ Why?_____

Ever had surgery? When? _____ Why?_____

Ever had an overdose of medication or swallowed a poisonous material? _____ If yes, please explain.

Ever had a seizure? _____ If yes, please describe.

Medication used to control seizure _____ Date of last seizure_____

Thank you for your cooperation.

_____ _____
Signature of Parent/Guardian Date