UPK/ Kindergarten Health Information

DATE: _____

NAME: _____ DATE OF BIRTH: _____

DOCTORS NAME AND PHONE NUMBER: _____

PREGNANCY: Illness or injury of mother? Describe _____

Bleeding? _____What month? _____

Medications? _____

Full term or Premature? _____ Birth weight _____

Additional information _____

LABOR AND DELIVERY: C-Section- scheduled or emergency? _____

Any anesthesia? _____

Complications, if any _____

NEO-NATAL PERIOD: Length of hospitalization _____

Any abnormalities, jaundice, breathing problems, infection? Describe _____

_____

DEVELOPMENTAL HISTORY: Please give the approximate age at which the child:

Sat alone _____ Stood alone _____ Walked alone _____

Spoke in sentences _____ Dressed self _____ Toilet trained _____

INFANCY and PRE- SCHOOL:

Any injuries requiring a doctor's care? _____

_____

Any hospitalizations: Why, when, where, how long? _____

_____

History of high fevers or seizure with fever? _____

MEDICAL OR PHYSICAL PROBLEMS: Asthma, Diabetes, food allergies? _____

_____

Current medications: _____

Allergies: food, medicine? _____

I AM AWARE THIS INFORMATION MAY BE SHARED WITH ANY NECESSARY STAFF

Parent/ guardian signature: _____ Date: _____