STRATFORD PUBLIC SCHOOLS
School Health Services
Kindergarten Registration – Health History

STUDENTS NAME **DATE OF BIRTH**

IMMUNIZATION RECORD
Please present a written, official copy (from your healthcare provider) of your child's immunization record to the school nurse at the time of kindergarten registration.

COMMUNICABLE DISEASES
Please check if your child has had any of the following with the approximate date.
Chicken Pox: Fifth Disease: Other:

RECURRENT INFECTIONS
Please check any frequent infections your child may have had.
Ear: ☐ Kidney and/or Bladder: ☐ Strep Throat: ☐ Other:

IMPORTANT HEALTH CONDITIONS
Please check any health conditions your child may have.
Heart Disease: ☐ Seizure Disorder: ☐ Diabetes: ☐ Muscle/bone Condition: ☐
Anemia: ☐ Congenital Defects: ☐
Other: ☐ Explain:
Accidents with Serious Injuries: ☐ Explain:
Surgery: Yes ☐ No ☐ Explain:
Hospitalization: Yes ☐ No ☐ Reason:

ALLERGIES
Please check any health conditions your child may have.
Asthma: ☐ Environmental: ☐ Bee Stings: ☐ Insect: ☐ Eczema: ☐ Drugs: ☐ Food: ☐
Other: ☐ Explain: (Name of food, drug, etc. and type of reaction)

DEVELOPMENTAL HISTORY
Were there any difficulties during the pregnancy: Yes ☐ No ☐
Was the pregnancy full term? Yes ☐ No ☐
Was the delivery normal? Yes ☐ No ☐
Birth Weight: Length:
Were there any serious problems during infancy: Since then? Yes ☐ No ☐
If yes, please explain:

DENTAL DEVELOPMENT
Check the ones that apply.
Eruption of Teeth: ☐ Normal ☐ Abnormal ☐ Delayed ☐
Thumb and/or Finger Sucking: ☐ Grinds Teeth: ☐ Mouth Breather: ☐
Name of Dentist: Last check-up date:

SUPPLEMEMENTAL HEALTH INFORMATION
1. Is your child under a doctor's care for any medical condition now? Yes ☐ No ☐
   If yes, explain and give doctor's name on the reverse side of this form.
2. Is your child presently on any medication? Yes ☐ No ☐ If yes, what kind:
   If yes, what is the nature of the problem?

3. Does he/she have any orthopedic (muscle/bone) problems? Yes☐ No☐
   If yes, what is the nature of the problem?
4. Are there any physical limitations or restrictions placed upon your child? Yes☐ No☐
   If yes, please explain:
5. Does anyone in your family have a history of a serious problem? (I.e. diabetes, high blood pressure, heart disease, tuberculosis, etc.) Yes☐ No☐
   If yes, please explain.

VISION, HEARING AND SPEECH

1. Has your child ever had his/her vision checked: Yes☐ No☐ Date of visit:
   Wears glasses? Yes☐ No☐ Name of Doctor:
2. Has your child ever had his/her hearing checked? Yes☐ No☐ Where:
3. Has your child had therapy for speech and/or hearing problems? Yes☐ No☐
   If yes, by whom: When: How long:
   Are you concerned about your child's speech? Yes☐ No☐

HEALTH HABITS

PLEASE DESCRIBE IN A FEW WORDS.
Eating habits:
Sleeping habits:
Toilet Training:

SCHOOLS

What other school has your child attended? (Nursery, Bible, Vacation, Camps, etc.)

COMMENTS

Please share any additional information you would like about your child.