

Preschool/Kindergarten
Carlisle School Annual Health Review School Year _____

Student Name _____ Date _____ Birth Date _____ Grade _____

Parent Contact Numbers: Mother: Name _____ Home _____ Cell _____ Work _____
 E-mail _____ Place of work _____ Lives with mother
 Father: Name _____ Home _____ Cell _____ Work _____
 E-mail _____ Place of work _____ Lives with father

If the primary and secondary contacts cannot be reached, whom should we contact?

Name: _____ Relationship _____ Phone number _____
 Name: _____ Relationship _____ Phone number _____
 Name: _____ Relationship _____ Phone number _____

Health Review

Breathing Problems	Heart Problems	Neurologic Problems	Eating Problems	Gland Problems	Orthopedic
___ Asthma	___ Heart Murmur	___ Frequent Headaches	___ Stomach Problems/Ulcer	___ Diabetes	___ Broken Bones
___ Reactive Airway	___ Heart Surgery	___ Dizziness ___ Fainting ___ Seizure	___ Bowel Problems	___ Thyroid	___ Orthopedic Braces
___ Other Problems	___ Other Problems	___ ADHD/ADD	___ Special Diet at School	___ Kidney	___ Other Problems

Early Childhood Health History (Check those that apply) ___ Mother received medical care during her pregnancy ___ Mother was ill during her pregnancy
 ___ Child was born early ___ Child weighed less than 5 pounds ___ Child had trouble starting to breath at birth ___ Child was able to leave the hospital with the mother
 ___ Child could say any words by 1 ½ years of age ___ Child developed at the same rate as other children of the same age
 Comments: _____

Dental History (Check all that apply) ___ Child has visited a dentist Any dental concerns _____

Dr. Ordered Special Needs (please attach): ___ Glasses ___ Hearing Aids ___ Seat Close to Instruction ___ Liberal Bathroom Privileges ___ Physical Education Limits

List Your Child's Allergies: Food _____ Medicine _____ Environmental _____

List any illnesses, operations, or accidents your child has had in the past year: _____

List any emotional, social, or other conditions that might affect your child's school performance: _____

Past history: Hearing problems _____ Vision problems _____

List other health concerns you would like the nurse to know about: _____

Current Medications: _____ **Medications to be given at school:** _____

Emergency Information: Doctor Name: _____ Number: _____ Hospital of Preference: _____
 Dentist Name: _____ Number: _____

****In case of serious accident and illness at school, your child will be sent to an emergency medical facility. The parent(s)/guardian is responsible for all expenses.**

Health Insurance Information: ___ Private ___ Medicaid ___ Hawk-i ___ No Insurance **Dental Insurance:** ___ Yes ___ No

Health Information/Screening: The school nurse may share educationally relevant health and emergency information (to include medical diagnosis) with school staff on a need to know basis. During the course of the school year we will do screenings for vision and hearing. Grade levels included in the screening are determined annually. The vision screening is conducted by the school nurse and the hearing screening is conducted by AEA.

Parent/Guardian Signature _____ Date _____