Saint Wenceslaus School Kindergarten Health History

Student Name _____ Date of Birth _____

Male _____ Female _____

Student's last physical _____date _____clinic _____physician_____

In order to better maintain your child's health & safety, please check any or all areas of concern:

- ❑ **Asthma**
- ❑ **Allergies**
  - — **Bee sting (mild or severe)**
  - — **Food _____**
  - — **Hayfever/Seasonal**
- ❑ **Diabetes**
- ❑ **Emotional/Behavioral**
  - — **ADD(H)**
  - — **Anxiety**
  - — **Depression**
  - — **Other_____**
- ❑ **Epilepsy/Seizures**
- ❑ **Headaches**
  - — **Treated with _____**
- ❑ **Hearing concerns**
  - — **Wears hearing aid (L R)**
  - — **Earaches**
  - — **Loss of hearing (L R)**
- ❑ **Injury/Trauma**
  - — **Head**
  - — **Other _____**
- ❑ **Heart Condition**
  - — **Dizziness/Fainting**
  - — **Other**
- ❑ **Nosebleeds ___ frequent**
- ❑ **Sinus Infections ___ frequent**
- ❑ **Sore throats/colds ___ frequent**
- ❑ **Vision Concerns**
  - — **Wears glasses**
  - — **Wears contacts**
  - — **Other _____**
- ❑ **Stomach concerns**
  - — **Stomachaches**
  - — **Ulcers**
  - — **other**
- ❑ **Weight concern**
  - — **Gain**
  - — **Loss**
- ❑ **Other Health Issues**
  - — _____
    _____
    _____

Any complications during pregnancy, labor or delivery? ____yes____no

Explain_____

Any hospitalization since birth?___yes _____no date_____

Explain _____

Is your child on medication? _____yes ____no Name of medications _____

<u>*The Medication Administration Form needs to be completed for all medication given at school.</u>**

Are there any toileting concerns (day/night wetting/frequency/urgency)___yes ___no

Explain _____

Are there any health issues school/staff need to know _____

_____

Are there problems or concerns at home that may affect your child's learning? _____

❑ **Check here if your child <u>DOES NOT</u> have any health concerns**

_____ _____

Parent/Guardian Signature Date