

SCHOOL HEALTH RECORD 2011-2012
(to be completed by Parent/Guardian)

CHILD'S NAME: _____ BIRTHDATE: _____

DISTRICT: _____

HEALTH CONDITIONS: Please check any that your child has had.

- | | | |
|---|--|---|
| <input type="checkbox"/> Allergies | <input type="checkbox"/> Chickenpox | <input type="checkbox"/> Heart Disease |
| <input type="checkbox"/> Anaphylactic reaction | <input type="checkbox"/> Cystic Fibrosis | <input type="checkbox"/> Hepatitis |
| <input type="checkbox"/> Asthma or Wheezing | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Juvenile Arthritis |
| <input type="checkbox"/> Attention deficit disorder | <input type="checkbox"/> Ear Problems/poor hearing | <input type="checkbox"/> Kidney disease |
| <input type="checkbox"/> Behavior/Emotional concerns | <input type="checkbox"/> Eczema/skin conditions | <input type="checkbox"/> Lice concerns |
| <input type="checkbox"/> Birth/congenital malformations | <input type="checkbox"/> Eye problems/poor vision | <input type="checkbox"/> Meningitis/Encephalitis |
| <input type="checkbox"/> Blood problems | <input type="checkbox"/> Frequent headaches | <input type="checkbox"/> Seizures/Epilepsy |
| <input type="checkbox"/> Bone/joint problems | <input type="checkbox"/> Frequent sore throats | <input type="checkbox"/> Toothaches/dental problems |
| <input type="checkbox"/> Bowel problems/constipation | <input type="checkbox"/> Frequent ear infections | <input type="checkbox"/> Urinary tract infections |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Feeding concerns-swallowing | |

*Is your child enrolled in BCMH? Yes _____ No _____
 Is your child receiving assistance from MRDD? Yes _____ No _____
 Are you in need of Community Services? (Food/Clothing /Medical assistance) Yes ___ No ___

Allergies:	
Allergy to:	Reactions/Recommended treatment if severe:

Medications: Describe medicine your child takes regularly:			
Name:	Taken for:	How Often:	What time?

If your child must take medication at school, please request a Medication Authorization form to be completed by you and your child's physician.

Assistance: Does your child need special assistance at school: Explain:

Does your family have Medical Insurance? _Yes _____No
 Does your family have Dental Insurance? _Yes _____No

Comments: Please add any comments or concerns you have about your child's health, development, behavior, family, or home life that you would like the school to be aware of:

If you have questions about your child's health, or community services that may be available to you, please contact the preschool office.

_____ Parent/Guardian Signature

_____ Date