**Anchorage School District**

### **PRESCHOOL HEALTH/MEDICAL HISTORY QUESTIONNAIRE**

**Name of Child**       Birthday       Male [ ]  Female[ ]

**Address**

**Parent/Guardian** **Home Phone:****Work/Cell Phone**

**Health/Medical History Informed Consent**

**Yes [ ]  No** **[ ]  has completed within 6 months a Medical/Social/Developmental History Form from other agencies prior to ASD preschool assessment. (If YES, provide copy of completed form)**

The disclosure of student health information within the school is limited to the information necessary to serve the student’s health or educational interest. Your signature gives permission for the nurse to inform school staff of precautions and procedures to protect your child in the classroom and to foster academic success.

**Your signature is an informed consent to share this health history information with school staff on a need-to-know basis for academic success and emergency plans, as determined by the nurse.**

**X**            \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 **Parent/guardian signature phone # date**

**Health Problem/Concern:**

**Please explain about any health problem that your child has now**

Yes[ ]  No[ ]  Is your child now under regular medical care for any conditions? If yes, what is the condition?

Yes[ ]  No [ ]  Does your child have allergies that could be a problem at school (foods, pet, insects)? If yes, please list:

Has your child experienced any of the following?

[ ]  asthma [ ]  seizure [ ]  diabetes [ ]  speech problem  [ ]  respiratory disorder  [ ]  digestive problem

[ ] kidney disease  [ ]  heart condition  [ ]  serious illness [ ]  serious accident  [ ]  surgery [ ]  head injury

[ ] hospitalization [ ]  other (explain)

Yes[ ]  No [ ]  Is your child taking any medications for above condition?

Yes[ ]  No [ ]  Does your child requires shoe inserts or braces? If yes, why

Yes[ ]  No [ ]  Does your child requires a wheelchair or stroller for getting around? (explain):

Yes[ ]  No [ ]  Does your child currently take a bottle? If so when?

**Date of last completed physical exam**       by MD/PA/ANP:

***It is wise to have a checkup before starting preschool. Any physical given up to 12 months before kindergarten will count as the school entry physical. Please ask the health care provider (*MD/PA/ANP) *to complete the school form and bring it with you when your child registers.***

**Medications:**

[ ] Takes medicine on a daily basis for (list medical condition):

What medicine Dose/Route Time given

***To have any prescription medication in school, we require that the medication form be completed by the parent and healthcare provider: MD/DO/ANP/PA & in a properly labeled pharmacy container. To have an Over-The-Counter medication at school, parent must complete a separate form and provide medication in an original container. \*\*\* Homeopathic remedies cannot be given at school.***

# Hearing Problems: Yes[ ]  No[ ]  If YES explain

# [ ]  frequent ear infection? [ ] as an infant [ ] more recently [ ]  has ear tubes, number of surgeries for ear tubes [ ]  problem with hard wax? [ ]  Hearing aid(s)? [ ] Audiology evaluation? [ ] Documented hearing loss

# Ear Dr.       Last exam date      Results of exam

# Vision Concerns: Yes[ ]  No[ ]  If YES explain

# Yes[ ]  No [ ]  wears glasses? If prescription is not current, please explain

# Yes[ ]  No [ ]  any vision concerns? If so, please explain

# Yes[ ]  No [ ]  has had a full eye exam, performed by an eye doctor (name) Dr.

# Yes[ ]  No [ ]  had eye surgery when?       Why?

***If your child has had professional hearing and/or vision evaluations, please see the Release of Information form attached.***

# Pregnancy and Birth History:

Yes[ ]  No[ ]  Did you experience problems (bleeding, high blood pressure, early contractions, etc.) during this pregnancy? Please explain

Yes[ ]  No[ ]  Did you take medications during this pregnancy? What and Why

Yes[ ]  No[ ]  Did you smoke? How long?

Yes[ ]  No[ ]  Did you drink beer, wine, alcohol? I f so, wow much?

Yes[ ]  No[ ]  Any use of recreational drugs during pregnancy? What kind?

Yes[ ]  No[ ]  Were there any difficulties during delivery? What kind?

**Newborn History:**

Yes[ ]  No[ ]  Was your child born on time? (Between 38-42 weeks)? If not, how early

Yes[ ]  No[ ]  Caesarian section, If Yes, why

Yes[ ]  No[ ]  Did your child go home with the mother? If not, please explain

Yes[ ]  No[ ]  Did your child need oxygen after birth? If so, how long?

Yes[ ]  No[ ]  Did your child turn yellow (jaundice) enough to be treated? If so, for how long?

Yes[ ]  No[ ]  Did your child has any complications that required a stay in the Neonatal Intensive Care Unit (NICU)?

Please explain:

Did your child have any of the following conditions?

[ ] Birth defect [ ] neurological disorders [ ] seizures [ ] muscular disorders [ ] chromosomal disorders [ ] Down’s syndrome [ ] Cystic Fibrosis [ ] heart problem If yes, please explain

Was your child?

[ ]  Strong [ ]  floppy [ ] fussy [ ]  mellow [ ] not gaining weight [ ] hard to calm or sooth [ ]  difficult to feed

[ ]  Other, please explain

**Early Developmental Milestones:** At what age did your child do the following?

Sit without help       months; Crawl       months; Walk       months; Play with toys      months Begin to use single words       months; Begin to use sentences       months; Feed him/herself     \_\_\_months;

Dress him/her self       months

Use the bathroom/toilet trained? No [ ]  Yes [ ]  at what age

Do you have any concerns about your child’s development? Yes[ ]  No[ ]  If YES explain

**Social & Behavioral History: Please** check any of the following that usually apply

[ ] gets along well [ ] is always moving [ ] shares [ ] acts shy [ ] quick to anger [ ] acts without thinking [ ] cries easily [ ] doesn’t listen [ ]  misunderstands [ ]  doesn’t remember instructions [ ]  prefers quiet activities [ ]  accident prone

[ ]  tunes out [ ]  is not able to sit still and listen to a story for 10 minutes [ ] strangers do not understand his/her speech

[ ]  other concerns      \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Previous Professional Services:**

Has your child been seen by any of the following? [ ] Psychiatrist [ ] Psychologist [ ] Social Worker

[ ]  Physical Therapist [ ]  Occupational Therapist

[ ]  Other specialist (list)

If yes, please list the name/s and dates seen

**Name of person parent/guardian (circle one), completing questionnaire (please print):**

**Signature:** **Date**

#### For Office Use Only

School Nurse review date: IEP meeting date:

School placement: School start date:

Date sent to Health Services (for medical concerns follow up):

Date sent to receiving school nurse: