Dayton Public Schools Preschool Programs Health History

Child's Name _____ Birth date _____ School _____

Name of medical insurance: None_____ Primary _____ Secondary _____

Prenatal History

Birth Weight _____lbs. _____oz.

Full Term ☐ Premature ☐ Late ☐

Did you receive prenatal care during the ☐ 1st ☐ 2nd ☐ 3rd trimester?

Mother's age at birth _____

Were drugs/alcohol used during pregnancy ☐ Yes ☐ No

Did baby require oxygen ☐ Yes ☐ No

Any feeding problems ☐ Yes ☐ No

Was infant breast-fed ☐ Yes ☐ No

Have jaundice ☐ Yes ☐ No

Birth defects/problems ☐ Yes ☐ No

If yes, please list

_____

_____

Does your child have any unusual birthmarks or "blue spots"? ☐ Yes ☐ No

Growth/Development

What age did your child?

Crawl_____ Sit alone_____

Walk _____ Dress self_____

Speak with meaning_____

Stop using a bottle_____

Is your child toilet trained?

☐ Yes ☐ No If yes, at what age_____

Does child wear diapers or pull-ups?

☐ Yes ☐ No

How often does your child have toileting accidents?_____

Physician/Dentist

Physician/Clinic

Name_____

Address_____

Telephone_____

Dentist/Clinic

Name_____

Address_____

Telephone_____

Does child have any of the following?

Missing Teeth ☐ Yes ☐ No

Dental Caps ☐ Yes ☐ No

Loose Teeth ☐ Yes ☐ No

Cavities ☐ Yes ☐ No

Difficulty Eating ☐ Yes ☐ No

Other Dental Problems ☐ Yes ☐ No

Describe_____

How often does your child brush teeth?

_____

Health History

Has your child ever been seen by a dentist? ☐ Yes ☐ No

Has your child had any of the following?

Allergies ☐ Yes ☐ No

Anemia ☐ Yes ☐ No

Asthma ☐ Yes ☐ No

Bleeding Tendencies ☐ Yes ☐ No

Bone/Joint Disorders ☐ Yes ☐ No

Broken Bones ☐ Yes ☐ No

Chicken Pox ☐ Yes ☐ No

Developmental Delays ☐ Yes ☐ No

Diabetes ☐ Yes ☐ No

Ear Infections, 3 or more ☐ Yes ☐ No

Headaches ☐ Yes ☐ No

Hearing Difficulties ☐ Yes ☐ No

Heart Disease ☐ Yes ☐ No

Hepatitis ☐ Yes ☐ No

Meningitis ☐ Yes ☐ No

MRSA ☐ Yes ☐ No

Nervous Habits ☐ Yes ☐ No

Over Weight ☐ Yes ☐ No

Phobias (Fears) ☐ Yes ☐ No

Rheumatic Fever ☐ Yes ☐ No

Seizures ☐ Yes ☐ No

Sickle Cell Disease ☐ Yes ☐ No

Sickle Cell Trait ☐ Yes ☐ No

Skin Rashes/Infections ☐ Yes ☐ No

Speech/Language Impairment ☐ Yes ☐ No

Tonsil Surgery ☐ Yes ☐ No

Trouble Sleeping ☐ Yes ☐ No

Tuberculosis ☐ Yes ☐ No

Urinary Infections ☐ Yes ☐ No

Whooping Cough ☐ Yes ☐ No

Emotional Problems ☐ Yes ☐ No

If yes, explain_____

_____

Exhibit destructive behavior ☐ Yes ☐ No

If yes, explain_____

_____

Surgery/Hospital Stay ☐ Yes ☐ No

If yes, what kind and date

_____

Has your child ever had a serious accident- broken bones, head injuries falls and/or burns? ☐ Yes ☐ No

If yes, explain_____

_____

List any diseases or conditions not listed:

_____

_____

Allergies (Identify)

Does your child have any allergies to the following?

Drugs_____

Plants/Animals_____

_____

Does your child take medication for allergies?

_____

Name of medication_____

_____

_____

Taken how often_____

Nutrition History

Is your child on a special diet? ☐ Yes ☐ No

If yes, explain_____

_____

Does your child have any food allergies?

☐ Yes ☐ No If yes, explain_____

_____

Does your child eat any non-food items?

☐ Yes ☐ No If yes, explain_____

_____

Does your child take vitamins? ☐ Yes ☐ No

If yes, were they prescribed? ☐ Yes ☐ No

Does your child receive WIC? ☐ Yes ☐ No

Medication/Treatment

List medications taken daily or frequently

_____

_____

_____

_____

Taken how often_____

If your child receives therapy, what type and where?

_____

_____

_____

Does your child use an EpiPen? ☐ Yes ☐ No

Other Information

Does your child have any of the following?

Glasses ☐ Yes ☐ No

Tubes in ear(s) ☐ Yes ☐ No

Right: _____ Left: _____ Both: _____

I understand that if my child has a medical or religious need for a special diet, I must submit the required form before my child may start.

Parent/Guardian _____ Date _____

Staff _____ Date _____