CABOT PUBLIC SCHOOLS

ARKANSAS DEPARTMENT OF EDUCATION

KINDERGARTEN HEALTH HISTORY

DEVELOPED BY A COMMITTEE OF THE ARKANSAS HEALTH CARE ACCESS COUNCIL

NOTE: To be completed by the parent/guardian of the Kindergarten student prior to the physical examination/nursing assessment.

PLEASE PRINT.

Student Name: _____ _____ _____
First Middle Last

Birthday: _____/_____/_____ School: _____

Medicaid Number: _____ Medicaid Physician: _____

Parent/Guardian Name (Male): _____Phone: _____

Parent/Guardian Name (Female): _____ Phone: _____

Physician Name, Address, & Phone: _____

Dentist Name, Address, & Phone: _____

Other source(s) from which your child receives health care: _____

Name and Address of private health insurance carrier:_____

Please answer questions 1-14 by circling "Yes" or "No".

1. Does your child pay attention when you read to him/her? *Yes No*
2. Can your child play quietly alone for over ½ hour? *Yes No*
3. Does your child mind adults and follow instructions? *Yes No*
4. Does your child speak clearly enough for others to understand? *Yes No*
5. Does your child object to being left with a sitter? *Yes No*
6. Can your child dress without help? *Yes No*
7. Does your child have any speech problems (stammering, delayed speech development, etc.)? *Yes No*
8. Does your child ever wet or soil him/herself during the day? *Yes No*
9. Do you have any concerns about your child's general health (eating and sleeping habits, bowel or bladder, posture, teeth, skin, weight, etc.)? *Yes No*
10. Does your child have any eye problems (difficulty seeing, crossed eyes, frequently reddened or watery eyes, wear glasses or contact lenses)? *Yes No*
11. Does your child have any ear or hearing problems (frequent earaches, difficulty hearing, draining ear, use a hearing aid, etc.)? *Yes No*
12. Does your child have any allergies (food, insects, drugs, pollens, etc)? *Yes No*
13. Does your child have any specific sickness that might in your opinion affect his/her school performance or program? *Yes No*
    (a) Has your child received any medical evaluation or other evaluation, the findings of which could help school personnel in meeting his/her health or educational needs? *Yes No*
    (b) Does this problem require any health care in the school? *Yes No*
    (c) Does your child take medication? *Yes No*
14. Do you have any concerns about your child's developmental behavior or emotional well being of which the school should be aware? *Yes No*

If you answered yes to questions 7-14, please describe the problem or concern you have on the back of this form.

By signing below, I understand that information provided on this form may be shared with appropriate personnel for health and education purposes.

_____ _____
Parent Signature Date