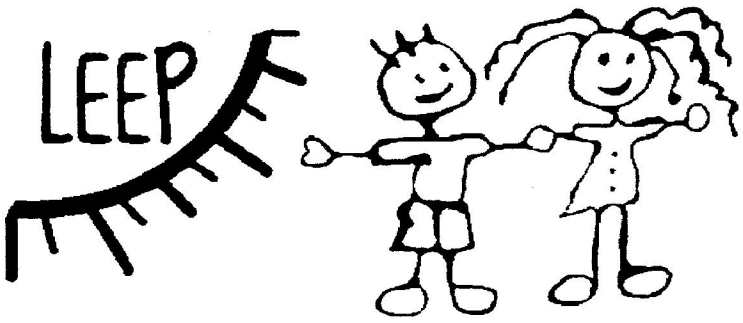
Laclede Early Education Program



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STUDENT HEALTH INFORMATION

CURRENT HEALTH ISSUES

Allergies Yes_____No_____ To drugs, food, insects, pollen?
Please list: _____

Bee Sting Allergy Yes_____No_____ Describe reaction: _____
Any difficulty breathing? _____
Emergency medication needed? _____

Asthma Yes ____No_____ Triggered by:_____Treatments:_____
Diagnosed by doctor: _____

Diabetes: Yes ____No_____ Take insulin? _____ Date diagnosed: _____

Seizures Yes ____No_____ Describe seizure: _____
Date of last seizure: _____ Medication: _____
Is student under a doctor's care for seizures? _____
Doctor's name: _____

Heart Condition Yes ____No_____ Describe: _____
Any physical conditions? _____
Medications: _____

Bone/ Joint Yes ____ No_____ Describe: _____
Any physical restriction? _____
Medication:_____

COMPLETE THE FOLLOWING REGARDING HEALTH CONCERNS THAT PERTAIN TO YOUR CHILD

Medication: Takes daily medication at home? Yes ____ No ____
Name of medication: _____
Reason for taking: _____

Eyes: Glasses Yes ____ No ____

Ears: Frequent Infections Yes ____ No ____ Tubes: Yes ____ No ____
Hearing Aid _____ Right _____ Left _____ Worn at school? Yes _____ No

Describe any speech or motor problems that your child has shown:

_____

_____

_____

Who first noticed the problem: _____

Has the problem changed over time: _____

Is your child aware of the problem: _____

How do you try to help the child with the problem: _____

_____

_____

Has the child ever had physical, occupational or speech therapy? _____

If yes, please answer the following:

A. Did he/she improve: Yes _____ No _____

B. Name of Agency or Therapist: _____

Address: _____

Phone: _____ Dates of Therapy: From _____ To: _____

GROWTH AND DEVELOPMENT

List your child's age when he/she could do the following

_____ Sit alone _____ Say single words _____ Became toilet trained

_____ Walk alone _____ Use two word sentences

Is this child's development different from other children in the family? Yes _____ No _____

PAST MEDICAL HISTORY	YES	NO
BIRTH		
Did the child have any difficulty during birth?	____	____
Did the child weigh less than five pounds at birth?	____	____
INFANCY/CHILDHOOD		
Did the child have any problems after birth, while in the hospital?	____	____
Did the child have any birth defects noted?	____	____
Did any problems develop at home in the first few weeks?	____	____
Did child have any problems with: (circle)		
Feeding Sucking Seizures Breathing Hear		
Is there a history of deafness in the family?	____	____
Is there a history of lazy eye or vision problems in the family?	____	____
Has the child had any illness with high fevers (over 104 for 2 days)	____	____
Has the child had: (circle) at what age?		
Meningitis _____ Pneumonia _____ Strep Infections _____		

Mumps _____ Measles _____ German Measles _____

	YES	NO
Has the child been hospitalized since birth for any reason?	____	____
If yes, what reason? _____		
Has the child had one or more serious accidents?	____	____
Has the child had an accidental poisoning?	____	____
If yes, what age _____		
Has the child had one or more head injuries?	____	____
Has the child ever been unconscious due to injury?	____	____
Has the child had any special tests for health problems?	____	____
Does the child have any chronic health problems?	____	____

GENERAL

Does the child have any physical limitations?	____	____
Do you have any concerns about your child's health (circle)	____	____
appetite excess thirst sleep problems energy level nervous habits		

SKIN

Does your child have problems with: (circle)	____	____
rashes bruises lumps spots		

EYES

Does child complain of frequent headaches?	____	____
Does child have problems with eyes: (circle)	____	____
squinting crusty lids watering mattering redness		
Does child's eye wander or cross?	____	____
Does child turn head to use one eye only?	____	____
Does child tilt head to one side, or cover or close eyes?	____	____
Does child hold object close to eyes to look at it?	____	____

TEETH

Has child ever had a toothache?	____	____
Was child more than twelve months before first tooth?	____	____
Do you have: (circle) well water or non-fluoridated water	____	____
Does your child drink from a bottle or a sippy?	____	____

EAR, NOSE THROAT

Has the child had earache or discharge from the ear?	____	____
Does the child seem to have trouble hearing?	____	____
Has the child had more than one throat infection?	____	____

SKELETAL

Does the child complain of pain in: (circle)	____	____
arms legs back joints		
Does the child: (circle)	____	___

limp walk funny toe in or out

	YES	NO
Has the child had a: (circle) broken bone cast brace corrective shoes	____	____

LUNGS

Does the child have more than four bad colds per year?	____	____
Does the child develop a severe cough with colds?	____	____
Does the child ever seem short of breath or wheeze?	____	____

BOWEL AND BLADDER

Does the child complain of frequent stomach aches?	____	____
Does the child have foods that disagree with him/her?	____	____
Does the child have: (circle) diarrhea constipation vomiting	____	____
Does the child have bladder or bowel problems: (circle) bedwetting soiling wetting during play pain	____	____
Does the child require catherization?	____	____
Does the child require diapering?	____	____

NERVOUS SYSTEM

Is child more clumsy than other children?	____	____
Has the child had any convulsions or seizures?	____	____
Have you noticed child having staring spells?	____	____
Does the child seem to have any weakness in any body parts?	____	____

BEHAVIOR

Do you have any concerns about your child's behavior?	____	____

Check the appropriate line if you have any concerns about the following behaviors:

___ bad dreams	___stammering, stuttering, poor speech
___biting nails	___irritable, easily upset
___thumb sucking	___nervous habits of any kind
___restlessness	___poor bowel control
___breath holding	___clumsy and awkward
___jealously	___destroys things on purpose
___lying	___selfish, unable to share
___disobedient	___contrary, stubborn, uncooperative
___anger	___feelings hurt easily
___glum, sulky, moody	___daydreams, seems preoccupied
___bad temper	___wants to much attention or comfort

NUTRITION

Does the child have any food intolerances or strong dislikes that prevent him/her From eating food in any of the following groups:	____	____

milk meat fruits/vegetables bread/cereal

Circle the foods eaten daily:

milk meat fruit vegetables bread/cereal

Does the child have difficulty feeding himself/herself? ____ ____

Does the child have difficulty drinking from a glass/cup? ____ ____

Does the child snack between meals? ____ ____

Do you have concerns for child's eating behavior? ____ ____

Has it been more than one year since child has had a blood test for iron deficiency anemia? ____ ____

LEAD EXPOSURE

Does your child eat/chew non-food items: ____ ___

pencils paint ice woodwork

Do you live in house built before 1960? ____ ____

Has child been tested for lead levels? Results? _____

DENTAL

Do you or your child brush his/her teeth daily? ____ ____

Do you floss your child's teeth? ____ ____

If your child is older than three, has he/she been to the dentist for a check up? ____ ____

Has it been less than a year since child has seen a dentist? ____ ____