CATHOLIC CHURCH OF INCARNATION PRESCHOOL
CHILD'S HEALTH HISTORY CHECKLIST

CHILD'S NAME:_____ DATE:_____

Please answer the following questions regarding your child. This information will help us when working with your child. It is important to have this information in event your child should become ill or have an accident while attending school. Please circle the correct answer. If answering yes, please explain in the comments section. All information provides remains confidential. Thank you.

PREGNANCY AND BIRTH

YES NO 1. Were there any problems with pregnancy or your child's birth?
YES NO 2. Was your child's birth weight less than 5 ½ pounds?
YES NO 3. Did the baby have any problems in the hospital?

Comments_____

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MEDICAL PROBLEMS

YES NO 4. Has your child ever been in the hospital overnight?
YES NO 5. Does your child take any medications on a regular basis?
YES NO 6. Any allergies or reactions to medications, DPT or other shots?
YES NO 7. Has your child ever had asthma or wheezing?
YES NO 8. Does your child have speech or hearing problems?
YES NO 9. Has your child had more than two ear infections in a year?
YES NO 10. Does your child have tubes in their ears?
YES NO 11. Has your child had tonsillitis or strep?
YES NO 12. Does your child have any vision problems?
YES NO 13. Does your child wear glasses?
YES NO 14. Has your child ever had a bladder or kidney infection?
YES NO 15. Does your child experience any burning while urinating?
YES NO 16. Does your child have seizures or staring spells?
YES NO 17. Have you ever been told your child has a heart murmur?
YES NO 18. Is your child allowed to play as hard as other children?
YES NO 19. Has your child ever had a bumpy, swollen reaction to a TB skin test?
YES NO 20. Does your child have reoccurring diaper rashes?
YES NO 21. Is your child a hemophiliac (free bleeder)?
YES NO 22. Is your child on a heart monitor?
YES NO 23. Do you have any concerns about your child?
YES NO 24. Does your child have allergies or special dietary needs (food or other types)? List below.
YES NO 25. Does your child have any special needs/disabilities? Is your child currently receiving services (i.e. speech, OT, PT, a shadow)? Please explain under comments.

Comments_____

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