Greeley-Evans
Weld County School District 6
1025 NINTH AVENUE | GREELEY, COLORADO 80631
970-348-6000 | WWW.GREELEYSCHOOLS.ORG

DEPARTMENT OF STUDENT SUPPORT SERVICES

Health Services

5k-e

STUDENT HEALTH QUESTIONNAIRE—PRESCHOOL, KINDERGARTEN & NEW ELEMENTARY

Child's Name_____ Birth Date_____ Age____ Sex____
Parent's Name_____ Date completed_____
Doctor/Clinic_____ Date of Last Physical Exam _____ Results_____
Dentist/Clinic_____ Date of Last Dental Exam _____ Results_____
Form Completed by_____ Relationship to child_____
Medical Insurance_____ Medicaid _____ CHP Plus _____ None_____
If your child is on medication, please list medication, dosage, and when taken:_____
Please list any previous medications _____
Allergies: YES NO List and describe what happens: _____
If your child has ever seen a medical specialist, please explain: _____
Date of last vision test: _____ Where? _____ Results: _____
Does your child wear glasses or contact lenses? Yes_____ No_____
Date of last hearing test: _____ Where? _____ Results: _____
List any physical disabilities: _____
Has child been hospitalized? _____(reason and age at the time)
Has child been seen in Emergency room? _____(reason and age at the time)
Has child had surgery? _____(reason and age at the time)

Family History: Is there a family history of medical, social/emotional, or environmental concerns that might impact your child's ability to learn? Please explain any concerns: _____

_____

Physical Health: Explain any health problems or concerns: _____
If your child has a medical diagnosis, what is it? _____ Age diagnosed:_____

Circle if child has had any of the following

Frequent ear infections	Bladder/Kidney problems	Physical/Sexual Abuse	Diabetes
Pneumonia/Bronchitis	Stomach problems	Sleep concerns	Speech concerns
Asthma/Chronic Cough	Serious injuries	Hearing problems	Joint or bone problem
Heart problems	Head injury/concussion	Dental problems	Hand coordination concerns
Seizures	Eating/weight concerns	Vision problems (glasses/contacts)	Emotional/Behavioral problems
Skin problems	Anemia	Muscle problems	Large muscle skill concerns

Comments: _____
Pregnancy and Birth History: Mother's age at child's birth: _____
Circle health concerns during pregnancy: Excessive nausea/vomiting high blood pressure anemia swelling
Other: _____
List medications, drugs, alcohol, or tobacco used by the mother during pregnancy: _____
Was your child born on time? _____ weeks early _____ weeks late (Circle one): vaginal birth caesarean-section
Concerns/Comments: _____
Please circle and comment on any of the following that applied to the baby: oxygen used jaundice breathing problems feeding problems Comments: _____
Did child pass new born hearing screening? Yes____ No____
Developmental History: Age your child: walked along _____ began saying words_____ began combining words ____
Was speech clear? Yes _____ No____ Comments: _____
Age finished toilet training: _____

HEALTH PERMISSIONS (please circle)

Yes / No I give permission for my child to be treated with Acetaminophen (non-aspirin) for pain or fever.
Yes / No I give permission for my child to be treated with the following approved non-prescription first aid items: calamine lotion, cortisone ointment, liquid antacid (age 12 and over), anti-bacterial soap and alcohol for cleansing, antibiotic ointment, Carmex and Vaseline for dry lips, eucerin cream, lotion, salt water gargle. (If you object to the use of any of these items, please send a note to your child's school nurse stating why the medication is to not be used. Otherwise we will interpret this as permission to all mentioned above.)
Yes / No I give permission for the health office to share health information with school personnel on a need to know basis

_____

Parent/Guardian Signature _____ Date _____