# SAINT BERNADETTE SCHOOL

*~Building Faith ~Building Minds ~Building Futures*

## 2016-2017 KINDERGARTEN HEALTH CLINIC PARENT QUESTIONAIRE

CHILD'S NAME: _____ BIRTHDATE: _____

CHILD'S PREVIOUS MEDICAL HISTORY: _____

SURGERIES: _____YES _____NO IF SO, WHAT TYPE: _____

DATES OF SURGERIES: _____

IMMUNIZATION INFORMATION:

1. ARE YOUR CHILD'S IMMUNIZATIONS UP-TO-DATE? _____YES _____NO
2. DO YOU HAVE AN APPT. SCHEDULED THIS SUMMER? _____YES _____NO

ASTHMA: _____YES _____NO

INHALER: _____YES _____NO TYPE & DOSAGE: _____

DIABETES: _____YES _____NO

DEVELOPMENTAL DELAYS: _____YES _____NO

MEDICATIONS: _____YES _____NO

IF SO, PLEASE LIST: _____

ALLERGIES: (Environmental, animal, food, insect bites, medications, etc.)

_____YES _____NO TYPE OF ALLERGY: _____

EPI PEN: _____YES _____NO

SEIZURES: _____YES _____NO

PSYCHOLOGICAL HISTORY: _____YES _____NO

IF SO, PLEASE ELABORATE: _____

OTHER INFORMATION:

1. ANY HEART PROBLEMS YOU ARE AWARE OF? _____YES _____NO

   IF SO, ANY RESTRICITONS? _____
2. HAS YOUR CHILD EVER WORN GLASSES? _____YES _____NO
3. ANY KNOWN HEARING IMPAIRMENTS? _____YES _____NO

ANY OTHER INFORMATION THAT WOULD BE HELPFUL:

_____

_____

PARENT SIGNATURE _____DATE _____, 2016