ANCHORAGE SCHOOL DISTRICT
PRESCHOOL HEALTH / MEDICAL HISTORY QUESTIONNAIRE

Name of Child: ______________________________ Birthday: ___________ Gender: Male __ Female__

Name of Parent/Guardian: ______________________________ Phone:

This information is confidential. To ensure the health and safety of your child, the school nurse will share health information with school staff on a need to know basis. **It is the responsibility of the parent/guardian to notify the school nurse of any changes or updates in your child's health history.** Your signature below gives consent to release or exchange confidential health information between your child's medical providers and the Anchorage School District. Your signature also gives permission for the nurse to review and enter immunizations in the State of Alaska immunization registry (VacTrak), managed by the Epidemiology Section of the Alaska Department of Health and Social Services. You can remove permissions at any time by submitting your request in writing.

____ ________________________

Parent / Guardian Signature **Date**

What are your concerns about your child? (speech/developmental delay, personal safety, behavior, attention span, etc.)

____

Yes ☐ **No** ☐ Is your child now under regular medical care for any conditions?

If yes, please explain: ____

Provider / Pediatric Group: ___________________________ Date of last physical exam: ________________

Yes ☐ **No** ☐ Does your child have allergies that could be a problem at school (foods, pet, insects)?

If yes, please list: ____

Yes ☐ **No** ☐ Is your child prescribed medication for treatment of allergies?

If yes, please list: ____

Yes ☐ **No** ☐ Does your child have asthma?

Yes ☐ **No** ☐ Is your child prescribed medication for treatment of asthma?

If yes, please list: ____

Has your child experienced any of the following conditions?

☐ **Diabetes** ☐ **Digestive problems** ☐ **Head injury** ☐ **Heart condition** ☐ **Hospitalization** ☐ **Other**

☐ **Kidney disease** ☐ **Respiratory disorder** ☐ **Serious illness** ☐ **Seizures** ☐ **Surgery** ☐ **NONE**

Please explain: ____

Yes ☐ **No** ☐ Was your child born prematurely (less than 37 weeks gestation)?

Yes ☐ **No** ☐ Is your child taking any medications? If YES, please lists name, dosage and times given.

Medication: ____________________________ Dosage: ______________ Times Given: __________

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To have any prescription or over the counter medicine in school, ASD policy requires that the parents, physician and school nurse complete the ASD medication form. All medication must be in a properly labeled container.

Yes ☐ **No** ☐ Does your child use a wheelchair, walker, braces, inserts, or other orthotic devices?

Yes ☐ **No** ☐ Does your child have any eating issues or concerns? Please explain: ____________________

Yes ☐ **No** ☐ Does your child have concerns with toileting or elimination? ☐Toilet trained ☐Working on it

Hearing Concerns

Yes ☐ **No** ☐ Does your child experience frequent ear infections or have a history of frequent ear infections?

Yes ☐ **No** ☐ Has your child had surgery to place ear tubes? Number of surgeries: _________ ☐Right ☐Left

Yes ☐ **No** ☐ Has your child ever had a hearing screening or audiology evaluation? ☐Normal ☐Hearing loss

Provider: ____ Last Exam Date: ______________________

Vision Concerns

Yes ☐ **No** ☐ Does your child wear glasses?

Yes ☐ **No** ☐ Has your child had eye surgery? Number of surgeries: _________ Reason: ________________

Yes ☐ **No** ☐ Has your child ever had a vision evaluation from an eye doctor? ☐ Normal ☐Needs glasses

Provider / MD: ____ Last Exam Date: ______________________