MAYNARD

PUBLIC SCHOOLS

HEALTH SERVICES DEPARTMENT
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PRESCHOOL HEALTH SCREENING

Date: _____

Student Name: _____ DOB: _____

PRENATAL HISTORY

1. Was there any serious illness, accident, or medical problem during the pregnancy with this child? θ YES θ NO
   If YES, please describe: _____

2. Any birth complications? θ YES θ NO
   If YES, please describe: _____

HEALTH HISTORY

1. Has your child ever been hospitalized? θ YES θ NO
   If YES, please describe: _____

2. Has your child ever had any serious illnesses, accidents, or fractures (broken bones)? θ YES θ NO
   If YES, please describe: _____

3. Does your child have any allergies to:
   a. medications or injections? θ YES θ NO
   b. bee stings or insect bites? θ YES θ NO
   c. foods? θ YES θ NO
   d. other? θ YES θ NO
   If YES, please describe: _____

4. Does your child have any of the following:
   a. asthma? θ YES θ NO
   b. history of wheezing? θ YES θ NO
   c. eczema? θ YES θ NO
   If YES, please describe: _____

PLEASE COMPLETE OTHER SIDE

5. Does you child have any of the following conditions which effect hearing or vision:

a. difficulty hearing?	θ Yes	θ No
b. frequent ear infections?	θ Yes	θ No
c. PE tubes?	θ Yes	θ No
d. wear glasses?	θ Yes	θ No
e. other vision problems?	θ Yes	θ No

If YES, please describe: _____

6. Does your child take any medications? θ Yes θ No

If YES, please describe: _____

7. Has your child had any of the following:

a. frequent colds?	θ Yes	θ No
b. frequent sore throat/strep throat?	θ Yes	θ No
c. frequent stomachaches?	θ Yes	θ No
d. frequent nosebleeds?	θ Yes	θ No
e. seizures	θ Yes	θ No
f. frequent headaches	θ Yes	θ No
g. heart murmur	θ Yes	θ No
h. eating disorder?	θ Yes	θ No
i. unusual behavior?	θ Yes	θ No
j. bowel/bladders problems?	θ Yes	θ No
k. other	θ Yes	θ No

If YES, please describe: _____

8. Are there any other medical or emotional issues that the school should be aware of? _____

SIBLINGS (NAME & DATE OF BIRTH)

_____

_____

_____

_____

Child's Physician: _____ Date of Last Exam: _____

Child's Dentist: _____ Date of Last Exam: _____