ARKANSAS DEPARTMENT OF EDUCATION
KINDERGARTEN HEALTH HISTORY

DEVELOPED BY A COMMITTEE OF THE ARKANSAS HEALTH CARE ACCESS COUNCIL

NOTE: To be completed by the parent/guardian of the Kindergarten student prior to the physical examination/nursing assessment. PLEASE PRINT.

Student Name: _____ _____ _____
First Middle Last

Birthday: _____/_____/_____ School: _____

Medicaid Number: _____ Medicaid Physician: _____

Parent/Guardian Name (Male): _____ Phone: _____

Parent/Guardian Name (Female): _____ Phone: _____

Physician Name, Address, & Phone: _____

Dentist Name, Address, & Phone: _____

Other source(s) from which the student receives health care: _____

Name and Address of private health insurance carrier: _____

1. Does your child pay attention when being read to? Yes No
2. Can your child play quietly alone for over 1⁄2 hour? Yes No
3. Does your child mind adults and follow instructions? Yes No
4. Does your child speak clearly enough for others to understand? Yes No
5. Does your child object to being left with a sitter? Yes No
6. Can your child dress without help? Yes No
7. Does your child have any speech problems (stammering, delayed speech development, etc.)? Yes No
8. Does your child ever wet or soil him/herself during the day? Yes No
9. Do you have any concerns about your child's general health (eating and sleeping habits, bowel or bladder, posture, teeth, skin, weight, etc.)? Yes No
10. Does your child have any eye problems (difficulty seeing, crossed eyes, frequently reddened or watery eyes, wear glasses or contact lenses)? Yes No
11. Does your child have any ear or hearing problems (frequent earaches, difficulty hearing, draining ear, use a hearing aid, etc.)? Yes No
12. Does your child have any allergies (food, insects, drugs, pollens, etc)? Yes No
13. Does your child have any specific sickness that might in your opinion affect his school performance or program? Yes No
    (a) Has your child received any medical evaluation or other evaluation, the findings of which could help school personnel in meeting his/her health or educational needs? Yes No
    (b) Does this problem require any health care in the school? Yes No
    (c) Does your child take medication? Yes No
14. Do you have any concerns about your child's developmental behavior or emotional well- being of which the school should be aware? Yes No

If you answered yes to questions 7-14, please describe the problem or concern you have on the back of this form.

By signing below, I understand that information provided on this form may be shared with appropriate personnel for health and education purposes.

_____ _____
Parent Signature Date