

ARKANSAS STATE DEPARTMENT OF EDUCATION/HEALTH
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 (Last, First, Middle)	Birth Date (MO./DAY/YR.) / /	School	Medicaid Number Medicaid Physician
Parent/Guardian Name (Male) Phone	Parent/Guardian Name (Female) Phone		
Physician Name and Address (If no regular physician, write "None")			Phone
Dentist Name and Address (If no regular dentist, write "None")			Phone
Other source(s) from which the student receives health care (If none, write "None")			Phone
Name and address of private health insurance carrier:			
To be completed by parent/guardian (please circle one):			
1. Does your child pay attention when being read to?	Yes	No	
2. Can your child play quietly alone for over a ½ hour?	Yes	No	
3. Does your child mind adults and follow instructions?	Yes	No	
4. Does your child speak clearly enough for other to understand?	Yes	No	
5. Does your child have any speech problems (stammering, delayed	Yes	No	
6. Does your child object to being left with a sitter	Yes	No	
7. Can your child dress without help?	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 (foods, insects, drugs, pollens, etc.)?	Yes	No
13. Does your child have any specific sickness which might in your opinion affect his school performance or program?	Yes	No
a) Has your child received any medical 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 medications?	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 any of the preceding questions, please describe the problem or concern you have below:

Question Number	Description

Information on this form may be shared with appropriate personnel for health and educational purposes.

Parent's Signature_____ Date_____