Kindergarten Medical History Questionnaire
TO BE COMPLETED BY PARENT

STUDENT'S NAME_____ _____**DOB**_____
(*If you answer yes to any of the following questions please provide an explanation in the space provided)*

	YES	NO
Does your child have any medical history and/or ongoing medical conditions? _____	☐	☐
_____		
Has your child ever been hospitalized? _____	☐	☐
_____		
Has your child ever had surgery? _____	☐	☐
_____		
Does your child take medication regularly? _____	☐	☐
If yes, medication and reason_____	☐	☐
_____		
Does your child have any allergies to foods, insects and/or environmental? _____	☐	☐
_____		
Did anyone in your immediate family below age 50 (fifty) die of a heart attack suddenly?	☐	☐
Has your child ever been unconscious or lost memory from a blow on the head?	☐	☐

Are there any other information or health concerns that the school should be aware of in order to safeguard your child's health? (Please explain). _____
_____

_____

I understand that this confidential information will be shared with the school personnel deemed appropriate by the health professional in my child's building.

Parent/Guardian Signature:
_____**Date:**_____

Revised 1-22-2015