

# MAYNARD

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## PUBLIC SCHOOLS

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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?  YES  NO  
If YES, please describe: \_\_\_\_\_
2. Any birth complications?  YES  NO  
If YES, please describe: \_\_\_\_\_

#### HEALTH HISTORY

1. Has your child ever been hospitalized?  YES  NO  
If YES, please describe: \_\_\_\_\_
2. Has your child ever had any serious illnesses, accidents, or fractures (broken bones)?  YES  NO  
If YES, please describe: \_\_\_\_\_
3. Does your child have any allergies to:
- a. medications or injections?  YES  NO
  - b. bee stings or insect bites?  YES  NO
  - c. foods?  YES  NO
  - d. other?  YES  NO
- If YES, please describe: \_\_\_\_\_
4. Does your child have any of the following:
- a. asthma?  YES  NO
  - b. history of wheezing?  YES  NO
  - c. eczema?  YES  NO
- If YES, please describe: \_\_\_\_\_

PLEASE COMPLETE OTHER SIDE

5. Does your child have any of the following conditions which effect hearing or vision:
- a. difficulty hearing?  Yes  No
  - b. frequent ear infections?  Yes  No
  - c. PE tubes?  Yes  No
  - d. wear glasses?  Yes  No
  - e. other vision problems?  Yes  No

If YES, please describe: \_\_\_\_\_

6. Does your child take any medications?  Yes  No

If YES, please describe: \_\_\_\_\_

7. Has your child had any of the following:
- a. frequent colds?  Yes  No
  - b. frequent sore throat/strep throat?  Yes  No
  - c. frequent stomachaches?  Yes  No
  - d. frequent nosebleeds?  Yes  No
  - e. seizures  Yes  No
  - f. frequent headaches  Yes  No
  - g. heart murmur  Yes  No
  - h. eating disorder?  Yes  No
  - i. unusual behavior?  Yes  No
  - j. bowel/bladders problems?  Yes  No
  - k. other  Yes  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: \_\_\_\_\_