Kindergarten Student Health History
Mary Welsh Elementary School, Williamsburg, IA

**To be completed by parent/ guardian**

Name:_____ Gender:_____ Birth Date:_____
Last First MI

Does your child have any of the following, or does she/he have a history of any of the following? If yes, please explain in detail.

| | YES | NO | |
|---|---|---|---|
| 1. | ___ | ___ | Asthma |
| 2. | ___ | ___ | Seizures |
| 3. | ___ | ___ | Diabetes |
| 4. | ___ | ___ | Heart Problems |
| 5. | ___ | ___ | Depression/Anxiety |
| 6. | ___ | ___ | ADD/ADHD |
| 7. | ___ | ___ | Allergies to food, medication, bee stings, dust/pollen |
| 8. | ___ | ___ | Headaches |
| 9. | ___ | ___ | Vision problems wears glasses____ wears contacts____ |
| 10. | ___ | ___ | Hearing problems left ear____ right ear____ hearing aid(s)____ |
| 11. | ___ | ___ | Eating problems/dietary considerations |
| 12. | ___ | ___ | Bowel/bladder problems |
| 13. | ___ | ___ | Speech/language problems |
| 14. | ___ | ___ | Developmental Delay |

Details of health condition to which you answered "yes" above:

_____

_____

If your child takes medications, please list them:

_____

_____

Is there anything else you feel the school should know about your child that would help in understanding and planning for him/her?

_____

_____

_____

_____ _____

Name of parent/guardian completing form Date