Health Questionnaire For Kindergarten Parents

Child's Name _____ Birth Date _____

To help me get to know your child better, please read each question carefully, then check *Yes* or *No*. If you answer "yes" please describe the situation. Thank you!

1. Does you child have any food allergies? _____ No _____ Yes
   If so, please describe them:
   _____
   _____

2. Does your child have any non-food allergies? _____ No _____ Yes
   If so, please describe them:
   _____
   _____

3. Is your child on any medications? _____ No _____ Yes
   If so, please describe them:
   _____
   _____

4. Have you any specific health concerns about your child? _____ No _____ Yes
   If so, please describe them:
   _____
   _____

5. Do you have a family doctor/health care provider? _____ No _____Yes
Doctor's Name: _____

If you do not have a family health care provider, do you need help getting a health care provider or health insurance? _____No _____Yes
May the school nurse contact you about this? _____No _____Yes

6. Does your child have any trouble sleeping at night or does your child snore, awaken at night or seem very tired during the day? _____No _____Yes
If so, please describe:
_____
_____

7. Has your child been hospitalized or had significant injuries? _____No _____Yes
If so, please describe:
_____
_____

8. Are there recent changes or stressors in family life that you would like to share that could affect your child at school? _____No _____Yes
If so, please describe:
_____
_____

Parent Signature _____ Date _____

Danielle Wagner Plocki, BSN, RN
School Nurse