Hanáádlį Community School/Dormitory, Inc.

Health and Developmental Information Form

Kindergarten/First Grade

School Year: 2020-2021

Child's Name: _____ Male ☐ Female ☐ Birth date: _____

I. Health History:

A. Illnesses

1. Does your child have, or has your child had in the past, any of the following: (Check all that apply.)

Allergies	☐	**Heart condition**	☐
Anemia	☐	**Kidney condition**	☐
Arthritis	☐	**Low blood sugar**	☐
Asthma	☐	**Meningitis**	☐
Bleeding disorder	☐	**Neuromuscular disease**	☐
Cerebral Palsy	☐	**Orthopedic disability**	☐
Chicken Pox	☐	**Pneumonia**	☐
Coughs/colds (frequent)	☐	**Rheumatic Fever**	☐
Cystic Fibrosis	☐	**Seizures**	☐
Ear Infections (frequent)	☐	**Sickle cell disease**	☐
Gastrointestinal disorder	☐	**Vision impairment**	☐
Hearing impairment	☐	**Whooping cough**	☐
Diabetes	☐	**Other**_____	☐

Explain any items check above: _____

_____

2. Dr. Ordered Special Needs:
☐ Glasses/Contacts ☐ Hearing Aids ☐ Liberal Bathroom Privileges ☐ Physical Education Limits

3. Does your child take any medications? Yes ☐ _____ No ☐ _____
Explain: _____

4. Allergic Reaction to: ☐ Bees ☐ Foods: _____ ☐ Medications: _____
Explain: _____

5. Asthma Triggers: ☐ Exercise ☐ Pollens ☐ Molds ☐ Changes in Temperature
☐ Chalk ☐ Animals ☐ Dust/Mites ☐ Other: _____

6. Has your child had a fever of 104° or higher for more than a few hours? Yes ☐ _____ No ☐ _____
Did your child experience seizures with fever? Yes ☐ _____ No ☐ _____
Explain: _____

7. **Health Insurance:**
☐ Private ☐ Medicaid ☐ No Insurance

Emergency Information:
Doctor Name: _____ Primary Physician's Name: _____

II. Preschool Education Experiences

A. How many years and/or months has your child spent in any of the following?

Home day care_____ Day care center_____ Head Start/Pre-K _____

Home with parent(s)_____ Home with babysitter_____

Other:_____

B. Check any of the following materials your child uses at home or in day care.

☐ Crayons	☐ scissors	☐ pencil	☐ pens
☐ Markers	coloring book	☐ paste	☐ glue
☐ Paper	☐ finger paint	☐ bikes/trikes	☐ puzzles
☐ Blocks	☐ play dough		

III. Parental Concerns

If you believe your child has a special need, please circle your concern from the following:

A. Behavior – tantrums; is not able to accept limits, resists or refuses requests; is very shy; trouble getting along with other children; easily frustrated; hits, shoves, bites others.

B. Social Skills – does not play well with other children; does not separate easily from parent; will not work in a group; is left out of peer activities.

C. Speech/Language – speech is unclear or garbled; stutters, difficulty expressing what he/she wants or needs; often needs instructions repeated.

D. Self-help – toilet difficulties or accidents; feeding or dressing problems

E. Attention- distracted easily; short attention span; jumps from one thing to another.

F. Developmental Delays – is not learning at an average rate; delays in developmental milestones.

G. Movement – clumsy; difficulty using tools; hand/eye coordination problems; poor control of body movement.

H. Hearing – has trouble hearing; asks you to repeat or talk louder; favors one ear; startles at sudden noises.

I. Vision – eyes cross or turn out; squints, rubs eyes; tilts or turns head to focus on something eyes quiver.

Parent/Guardian Signature:_____ Date:_____