PRESCHOOL HEALTH FORM
MUST BE UPDATED ANNUALLY

Student Name: _____ School Year: _____ School: _____

Date of Birth: _____ Teacher (if known): _____

Is this student **generally in good health?** ☐ Yes ☐ No

Please list all **medical diagnoses:** _____

_____

Health concerns: (**please circle those that apply and describe below)**

ADD/ADHD	Autism	Congenital/Birth Disorder	Ears/Hearing Loss	Headaches	Physical Disability	Stomach/ Digestion
Allergies	Blood Disorder	Dental	Emotional	Heart	Respiratory	Vision
Allergies/Life Threatening	Bone/Joint	Developmental Delays	Eating	Neurological	Seizures	Weight Concerns
Asthma	Bowel/Bladder	Diabetes	Head Injuries	Prematurity	Speech	Other _____

Describe any concerns: _____

_____

_____

Special **instructions for care** of student (Please indicate any dietary or activity restrictions): _____

_____

Hospitalizations or surgeries: (Please list dates and reasons): _____

_____

Routine **medications?** ☐ Yes ☐ No

Medication(s)/Dose(s)/reason(s) for taking: _____

_____

_____

Physician Signature _____ Date _____

Parent/Guardian Signature _____ Date _____

PLEASE RETURN FORM TO YOUR PRESCHOOL TEACHER