

**SCHOOL HEALTH INFORMATION**

Boulder Valley School District  
Health Services

Student \_\_\_\_\_ Grade \_\_\_\_\_  
Birthdate \_\_\_\_\_ Age \_\_\_\_\_  
School \_\_\_\_\_ Date \_\_\_\_\_

Gender and ages of child's siblings \_\_\_\_\_

Who cares for your child before and after school? \_\_\_\_\_ Telephone \_\_\_\_\_

Did child attend preschool or Headstart? \_\_\_\_\_ Where? \_\_\_\_\_ For how long? \_\_\_\_\_

Child's Doctor \_\_\_\_\_ Date of last visit \_\_\_\_\_ Reason \_\_\_\_\_

Child's Dentist \_\_\_\_\_ Date of last visit \_\_\_\_\_ Reason \_\_\_\_\_

1. Briefly describe your child: \_\_\_\_\_  
\_\_\_\_\_

2. Mother's age at child's birth \_\_\_\_\_ Child's birth weight \_\_\_\_\_  
Child adopted at age \_\_\_\_\_ Place of birth \_\_\_\_\_

3. Check any of the following which happened during your pregnancy, labor, or delivery with this child. Bleeding  
High blood pressure Infections Excessive nausea Swelling Rh factor Illnesses Premature delivery  
Baby overdue Labor/delivery problems Breech presentation High weight gain Low weight gain  
Baby had: Breathing problems Jaundice Digestive problems Other: \_\_\_\_\_  
Baby did NOT go home with mother. Explain: \_\_\_\_\_

4. Check at what age your child walked: under 9 months 10-14 months after 15 months  
Used single words: under 18 months 18 months 2 1/2 years over 2 1/2 years  
Was toilet trained: under 12 months 12-24 months 2-3 years after 3 years  
Left handed Right handed Age established: under 2 2-4 years over 4 years

5. Check any of the following that describe your child: Cries easily Short temper Temper tantrums  
Won't mind Holds breath Eats dirt or paint Wears glasses Sad  
Sleeps soundly Restless sleep 2 or more nightmares per week Sucks thumb Angry  
Wets bed (2 or more times/wk) Wets clothes during day Soils clothes w/bowel movement during day  
Quiet child Has friends with whom plays well Very active child Doesn't pay attention  
Bangs head on purpose Tilts head when listening Tilts head when writing  
Explain \_\_\_\_\_

6. Check if there is a family history of any of the following: Diabetes Migraines Seizures TB  
Skin condition Frequent broken bones Allergies Asthma Hay-fever Kidney trouble  
Heart disease Dental problems Scoliosis Other \_\_\_\_\_

7. Does your child prefer to play: \_\_\_\_\_ alone \_\_\_\_\_ with other children \_\_\_\_\_ side by side \_\_\_\_\_ with one playmate  
\_\_\_\_\_ with several playmates \_\_\_\_\_ very brief time \_\_\_\_\_ moderately long time

8. Check activities your child likes to do: Ride bike Climb Swing Look at books Watch TV; hrs per day \_\_\_\_\_  
Draw or color Play in sand box Play with water Build with blocks Imitate parents Video games  
Educational computer games Group sports Board games Other: \_\_\_\_\_

9. Has child ever had any special testing? Yes No Describe: \_\_\_\_\_  
\_\_\_\_\_

10. Which does your child eat best: Breakfast Lunch Dinner After school snack Bedtime snack  
Do any foods bother child? Yes No Describe: \_\_\_\_\_  
Does child often have diarrhea? Yes No Does child often have constipation? Yes No  
Describe your child's appetite \_\_\_\_\_ Favorite foods & drinks: \_\_\_\_\_

11. Describe any problems older siblings have had with school: \_\_\_\_\_

**SCHOOL HEALTH QUESTIONNAIRE**

Boulder Valley School District  
Health Services

Student \_\_\_\_\_ Age \_\_\_\_\_  
School \_\_\_\_\_ Grade \_\_\_\_\_  
Date \_\_\_\_\_

**FOR ALL KINDERGARTEN AND STUDENTS NEW TO BOULDER VALLEY SCHOOLS**

*\*Life threatening implies respiratory distress or need for emergency care.*

**ALLERGIES**

\_\_\_ Food: type: \_\_\_\_\_ Life threatening\* \_\_\_ Severe \_\_\_ Mild reaction \_\_\_ Age at last reaction  
\_\_\_ Nuts: type: \_\_\_\_\_ Life threatening\* \_\_\_ Severe \_\_\_ Mild reaction \_\_\_ Age at last reaction  
\_\_\_ Insect: type: \_\_\_\_\_ Life threatening\* \_\_\_ Severe \_\_\_ Mild reaction \_\_\_ Age at last reaction  
\_\_\_ Medication:: \_\_\_\_\_ Life threatening\* \_\_\_ Severe \_\_\_ Mild reaction \_\_\_ Age at last reaction  
\_\_\_ Other: type: \_\_\_\_\_ Life threatening\* \_\_\_ Severe \_\_\_ Mild reaction \_\_\_ Age at last reaction

Describe reaction: \_\_\_\_\_

\_\_\_ Seasonal hay fever \_\_\_ May take medication \_\_\_ Medication may cause drowsiness

**ASTHMA**

\_\_\_ Life threatening\* \_\_\_ Severe \_\_\_ Mild \_\_\_ Manages own care \_\_\_ Needs supervision  
\_\_\_ Takes medication \_\_\_ Medication may cause drowsiness  
Causes: \_\_\_ Cold weather \_\_\_ Exercise \_\_\_ Stress \_\_\_ Respiratory infection \_\_\_ Exposure to: \_\_\_\_\_

**EYES**

Doctor name and date of last eye exam: \_\_\_\_\_

\_\_\_ Problem with: \_\_\_ Right \_\_\_ Left \_\_\_ Both eyes Surgery at age \_\_\_\_\_ for \_\_\_\_\_  
\_\_\_ Wears glasses \_\_\_ Contacts Last prescription change at age \_\_\_\_\_ Color blind  
\_\_\_ Other eye problem \_\_\_\_\_ Correctable \_\_\_ Yes \_\_\_ No

**EARS**

Doctor Name and date of last ear exam: \_\_\_\_\_

\_\_\_ History of ear infections, ages \_\_\_\_\_ Had or \_\_\_ Has tubes in \_\_\_\_\_ ear \_\_\_ Wears aid  
\_\_\_ Other problem with \_\_\_ Right \_\_\_ Left \_\_\_ Both ears Describe: \_\_\_\_\_

**HEART CONDITION**

\_\_\_ Murmur \_\_\_ Under medical care Activities are: \_\_\_ Restricted \_\_\_ Not restricted  
\_\_\_ Wears pacemaker \_\_\_ Other condition: \_\_\_\_\_

**HEADACHES**

\_\_\_ Migraines \_\_\_ Other Caused by: \_\_\_\_\_ Takes medication

**BONE PROBLEMS**

\_\_\_ Scoliosis \_\_\_ Knees \_\_\_ Bone spurs \_\_\_ Other Describe: \_\_\_\_\_  
Under treatment: \_\_\_ Yes \_\_\_ No Restrictions are: \_\_\_\_\_

**OTHER CONDITIONS:**

\_\_\_ Arthritis \_\_\_ Diabetics \_\_\_ Seizures \_\_\_ Cerebral Palsy \_\_\_ Dental  
\_\_\_ Birth Defects \_\_\_ Emotional \_\_\_ Hyperactive \_\_\_ Thyroid \_\_\_ Cystic Fibrosis \_\_\_ Psychiatric  
\_\_\_ Bladder/Kidney \_\_\_ Blood Disorder \_\_\_ Intestinal \_\_\_ Neurological  
\_\_\_ Frequent/Severe Nose Bleeds \_\_\_ Blood Pressure \_\_\_ Sleep Problems \_\_\_ Eating Problems

Other: \_\_\_\_\_

Describe above: \_\_\_\_\_

Medication \_\_\_ Yes \_\_\_ No Name of medication \_\_\_\_\_ Under Treatment \_\_\_ Yes \_\_\_ No

**DESCRIBE (include age)** \_\_\_\_\_ Hospitalizations \_\_\_ Surgeries \_\_\_ OT \_\_\_ PT \_\_\_ Counseling/Therapy

Your child's attitude toward school: \_\_\_\_\_

Significant stressors: \_\_\_\_\_

Concerns you have about your child: \_\_\_\_\_

Parent/Guardian Signature \_\_\_\_\_ Day Phone \_\_\_\_\_ Eve Phone \_\_\_\_\_