# Holy Cross Academy 2 year old Classroom
# Health and General Development Questionnaire
# Return form prior to June 1, 2018

Child's Name:_____ Today's Date _____

Child's Birthday:_____ Age:_____ Male/Female

Child's Current Weight:_____ Campus: St. Michael's / St. Dominic Savio

**Parent Page:** **General Development:**

1. Does your child see any Specialist or received services from First Steps? Yes / No
   If yes, please explain_____
2. Does your family participate in the Parents as Teachers program? Yes / No
   If yes, which school district: _____
3. Was your child full term or premature? If Premature, how many weeks:_____
4. Does your child show interest in using the toilet? Yes / No
5. Does your child tell you when they need to go to the bathroom? Yes / No
6. My child is potty trained completely? Yes / No , Please indicate date complete**:** _____
   **2 year olds aren't required to be potty trained to enter the 2 year old classroom**
7. Does your child feed themselves independently? Yes / No
8. Does your child drink from an open cup at meals? Yes / No
9. Does your child use a spoon independently at meals? Yes / No
10. Does your child use a pacifier during nap time? Yes / No
11. Is your child fearful of anything? Yes / No Please list: _____
(animals, loud sounds, storms, flushing the toilet etc…)

13. Which best describes your child's vocabulary? **Please check all that apply**

____Uses single words
____Puts 2-3 words together
____Uses less than 100 words
____Uses 100 – 200 words
____Uses 200 + words
____Points and labels objects in books
____Names animals and makes sounds
____Uses names: Mommy, Daddy, siblings or family members
____Greets and says good –bye to people
____Uses words to express needs: more juice, play ball, read book, go outside, etc….

Any other things you would like us to know about your child: _____

**Allergies / Asthma / Action Plans**

Does your child have any allergies? Yes / No Please list: _____
Does child require an Epipen? Yes / No
Does your child have asthma ? Yes / No What induces the asthma?_____
Does your child need an inhaler and air chamber at school? Yes / No

**Doctor page** **Immunizations: attach a copy of records from Doctors office**

| | D TaP (DPT) | P C V | In fluenza | Hib | IPV(Polio) | Hep B | M M R | Varicella |
|---|---|---|---|---|---|---|---|---|
| Dose 1 | | | | | | | | |
| Dose 2 | | | | | | | | |
| Dose 3 | | | | | | | | |
| Dose 4 | | | | | | | | |
| Dose 5 | | | | | | | | |
| | | | | | | | | |

Any other immunization:_____

Does your child have a current medical condition? Yes / No
Please list _____

Does child have regular ear infections? _____

Does child have ear tubes? _____

Medication taken regularly and reason:_____

Please list food allergies: _____

**If child needs an inhaler, allergy medication, EpiPen, Tylenol, Ibuprofen or over the counter medication Doctor must provide an Action Plan to school with possible symptoms, treatment and specific medication and dosage before child starts school.**

General Health Comments from the Doctor

I have examined, _____, and find that she/he is healthy and can attend a preschool program of the parent's choice.

_____ _____
Doctor's Name Doctor's Office Phone Number

_____
Doctor's Signature Date

**Holy Cross Academy**
**Fax # 314-270-8233**
**Attention: Preschool Program**