Holy Cross Academy Preschool (3-5yo)
Health & General Development Questionnaire

Return form prior to June 1

Child's Name:_____ Today's Date _____

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

Child's Current Weight:_____ Campus: SMA / OLP/ JP2

General Development:

1. What things can your child do very well? _____
2. What things are challenging for your child? _____
3. Does your child see any specialists or receive services from First Steps? Yes / No

   If yes, please explain: _____
4. Does your child have a current IEP or ISP from Special School District? Yes / No

   If yes, please attach a copy of the IEP.
5. Does your family participate in the Parents as Teachers program? Yes / No
6. Was your child full-term or premature? Yes / No

   If premature, How many weeks? _____
7. Is your child's speech understood 70% of the time, by others? Yes / No
8. Does your child climb well on playground equipment? Yes / No
9. Does your child pedal a tricycle? Yes / No
10. Is your child fearful of anything? Yes / No

    If yes, please list: _____

Allergies / Asthma / Action Plans

Does your child have any food allergies? Yes / No

Please list: _____

Does your child require an Epi-Pen? 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 Doctor's 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 immunizations:_____

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

Please list _____

Does child have regular ear infections? Yes / No

Does child have tubes in ears? Yes / No
If yes, please list the date_____

Is Medication taken regularly? Yes / NO
If yes, please explain 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