Holy Cross Academy Preschool Health Questionnaire
Return form prior to June 1, 2017

Child's Name:_____ Today's Date _____

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

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

Parent Page: 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 Specialist or received 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
   If yes, which school district: _____

6. Was your child full term or premature? If Premature, how many weeks:_____

7. Is 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 Please list: _____

Allergies / Asthma / Action Plans

1. Does your child have any food allergies? Yes / No Please list: _____
   Does child need a Epipen? Yes / No

2. Does your child have asthma ? Yes / No What induces the asthma?_____
   Does your child need an inhaler at school? Yes / No

If Benadryl, an Epipen, or an asthma inhaler is needed at school a Medical Action Plan must be provided from the Doctor. Plan should include symptoms, instructions on treatment and specific mediation and dosage. All Medication must be in original box or container from the pharmacy.

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

Doctor Page: **Return by June 1, 2017**

Child's Name: _____ **Date of Last Exam:** _____

Immunizations: OR 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 immunizations: _____

Does child have frequent ear infections? _____

Does child have tub in ears? Yes / NO if yes: date: _____

Date of hearing screening: _____ (if completed)

Date of vision screening: _____ Does child wear glasses? Yes / No

Known allergies: _____

Does child need an inhaler or epipen at school? _____

If child needs an inhaler, allergy medication, EpiPen, 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

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