Sacramento City Unified School District
CHILD DEVELOPMENT DEPARTMENT

PRESCHOOL HEALTH AND DEVELOPMENT HISTORY ☐ Yr1 ☐ Yr 2 ☐ Yr 3

Child's Name: _____ Birthdate: _____ ☐ M ☐ F

Preschool Site: _____ ☐ AM ☐ PM ☐ Full Day *(CC or Wrap)*

Medical Insurance: ☐ Medi-Cal ☐ California Covered ☐ None ☐ Private Insurance:_____

Name of Child's Doctor:_____ Phone:(_____) _____ Medical Plan:_____

Name of Child's Dentist: _____ Phone:(_____) _____ Dental Plan:_____

HEALTH HISTORY

Does your child have any of the following:

☐ Yes ☐ No Asthma or Reactive Airway Disease
☐ Yes ☐ No Has your child ever been prescribed an inhaler or nebulizer?
☐ Yes ☐ No Diabetes ☐ Type I (needs insulin injections) ☐ Type 2
☐ Yes ☐ No Heart problem: If Yes, describe: _____
☐ Yes ☐ No Seizures: If Yes, describe:_____
☐ Yes ☐ No Cerebral Palsy
☐ Yes ☐ No Does your child use mobility equipment? (leg/ankle braces, walker, wheelchair):_____
☐ Yes ☐ No Severe bee sting/insect bite allergy or Severe Scent allergy List: _____
☐ Yes ☐ No **Do you have concerns about how well your child can HEAR?**
☐ Yes ☐ No Myringotomy (vent) tubes in ears
☐ Yes ☐ No Hearing Aids
☐ Yes ☐ No **Do you have concerns about how well your child can SEE?**
☐ Yes ☐ No Eye or vision problems (child squints, eyes crossed, "lazy eye", etc.)
☐ Yes ☐ No Eyeglasses prescribed by doctor: If Yes, should glasses be worn at school? ☐ Yes ☐ No
☐ Yes ☐ No ☐ Sickle Cell Disease ☐ Sickle Cell Trait
☐ Yes ☐ No Eczema ☐ Other type of skin problem, describe: _____
☐ Yes ☐ No Anemia (low iron in blood). Last Hemoglobin/Hematocrit result _____
☐ Yes ☐ No Airborne allergies: If yes, to what?_____
☐ Yes ☐ No Is your child exposed to second or third hand (in clothes/furniture, etc.) tobacco smoke?
☐ Yes ☐ No Any major illness or surgery? Please describe:_____
☐ Yes ☐ No Other medical needs or concerns? Please describe: _____
☐ Yes ☐ No **Is your child seeing one of the following specialists:**
☐ ENT (ear, nose, throat doctor) ☐ Audiologist ☐ Neurologist
☐ Optometrist (eye doctor) ☐ Speech Therapist ☐ Other: _____
☐ Yes ☐ No **Has your child ever received services from:**
☐ Alta Regional Center ☐ California Children Services (CCS) ☐ Mind Institute (UCD)
☐ Shriner's Hospital ☐ Special Education Services ☐ Other:_____

MEDICATION

☐ Yes ☐ No **Does your child take any medication?**
If Yes, list: _____
☐ Yes ☐ No **Will your child need to take any medication *<u>at school</u>*?**
If Yes, list: _____

DENTAL HISTORY

☐ Yes ☐ No Has your child been seen by a dentist within the last 12 months?
Date of last dental appointment _____ Next appointment date _____
Does your child have any: ☐ cavities ☐ painful teeth ☐ painful gums
☐ Yes ☐ No Does your child drink from a bottle?

NUTRITION HISTORY

☐ Yes ☐ No **Is your child *allergic* to any foods? *(Please notify our preschool nurse)***
If Yes, List:_____

☐ Yes ☐ No **Has your child ever been prescribed an EpiPen or Antihistamine for this food allergy? (Please notify our preschool nurse)**

☐ Yes ☐ No **Is your child lactose intolerant?**

☐ Yes ☐ No **Is your child on a special diet or tube feedings? If Yes, describe:** _____

☐ Yes ☐ No Is there any food your child should not eat for *religious preference* reasons?
If Yes, List_____

☐ Yes ☐ No Is your child vegetarian / vegan?

☐ Yes ☐ No Does your child eat any non-food items (such as clay, dirt, chalk) on a regular basis?
If Yes, List_____
Is child's doctor aware of this condition? ☐ Yes ☐ No

☐ Yes ☐ No Does your child receive WIC? WIC Number: _____

How many times a day does your child have the following foods (includes school meals):

	1 - 2	3 - 5	> 6
Cake, cookies, candy, chips			
Soda, sweetened drinks			
Dairy: Milk, cheese, yogurt			
Non-meat: Beans, lentils, peanut butter			
Fruit: Apples, oranges, bananas			
Vegetables: Broccoli, carrots, green beans			
Grains: Cereal, bread, rice, grits, tortilla			

DEVELOPMENT HISTORY: *(complete for Year 1 only)*

☐ Yes ☐ No Walked by 14 months

☐ Yes ☐ No Used single words by 18 months

☐ Yes ☐ No Is toilet trained

☐ Yes ☐ No Developmental Concerns:_____

☐ Yes ☐ No Behavioral Concerns:_____

Child goes to bed by: _____ PM Wakes at: _____ AM Naps: ____ hours per day

PREGNANCY / BIRTH HISTORY: *(complete for Year 1 only)*

☐ Yes ☐ No Were there complications with the pregnancy or birth of this child? If yes, describe:
_____

☐ Yes ☐ No Did mother use any medications, alcohol, street drugs or tobacco during pregnancy? If yes describe: _____

☐ Yes ☐ No Did your child have any problems at birth of during first months of life? If yes, describe:
_____

☐ Yes ☐ No Was your child born early (premature)? If yes, born at _____ gestation

Please tell us anything else you would like us to know about your child's health: _____

_____

_____

By typing my full name, I confirm that the above information is true and correct.

_____ ☐ **Parent** ☐ **Grandparent** ☐ **Foster Parent**
Parent/Guardian Name

Reviewed by Preschool Nurse: _____ **Date:** _____