



SAINT BERNADETTE SCHOOL

“With Faith and Education, We Thrive Together”

2023-2024 KINDERGARTEN HEALTH CLINIC PARENT QUESTIONNAIRE

CHILD’S NAME: _____ BIRTHDATE: _____

CHILD’S PREVIOUS MEDICAL HISTORY: _____

SURGERIES: _____ YES _____ NO IF SO, WHAT TYPE: _____

DATES OF SURGERIES: _____

IMMUNIZATION INFORMATION

- ARE YOUR CHILD’S IMMUNIZATIONS UP-TO-DATE? _____ YES _____ NO
- DO YOU HAVE AN APPT. SCHEDULED THIS SUMMER? _____ YES _____ NO
- HX COVID INFORMATION
- DATE OF DIAGNOSIS: _____ 20____
- WAS YOUR CHILD HOSPITALIZED: _____ YES _____ NO
- TMT IF ANY: _____ YES _____ NO
- COVID VACCINE: _____ YES _____ NO
- DATE _____ 20____
- NEXT DUE DATE: _____ 20____

OTHER MEDICAL ISSUES

- ASTHMA: _____ YES _____ NO
- INHALER: _____ YES _____ NO TYPE & DOSAGE: _____
- DIABETES: _____ YES _____ NO
- DEVELOPMENTAL DELAYS: _____ YES _____ NO MEDICATIONS: _____ YES _____ NO

NAME OF MEDICATION: _____ DOSAGE _____ FREQUENCY _____

ALLERGIES: (Environmental, animal, food, insect bites, medications, etc.)

_____ YES _____ NO TYPE OF ALLERGY: _____

EPI PEN: _____ YES _____ NO SEIZURES: _____ YES _____ NO

PSYCHOLOGICAL HISTORY: _____ YES _____ NO

IF SO, PLEASE ELABORATE: _____

OTHER INFORMATION:

1. ANY HEART PROBLEMS YOU ARE AWARE OF? _____ YES _____ NO

IF SO, ANY RESTRICTIONS? _____

2. HAS YOUR CHILD EVER WORN GLASSES? _____ YES _____ NO

3. ANY KNOWN HEARING IMPAIRMENTS? _____ YES _____ NO

ANY OTHER INFORMATION THAT WOULD BE HELPFUL: _____

PARENT SIGNATURE _____ DATE _____, 2023