North Reading Public Schools
North Reading, MA 01864

Kindergarten Health Information

According to Massachusetts General Laws and the guidelines of the Massachusetts Department of Public Health, physical examinations are required for North Reading Public School students entering kindergarten.

The physical for school entry should be done by your child's primary care provider. Please submit your child's **five year old physical exam** with full immunization record.

In addition, students entering kindergarten must submit the following immunizations/tests/screenings ***before starting school:***

- **2 doses of Measles, Mumps and Rubella (usually MMR)**
- **2 doses of Varicella Vaccine (Chicken Pox) or a physician-certified history of the Chicken Pox disease.**
- **3 doses of Hepatitis B Vaccine**
- **5 doses of Diphtheria/Tetanus/Pertussis Vaccine (DTaP/DTP)**
- **4 doses of Polio Vaccine**
- **Proof of Lead testing with date and result**
- **Vision screening with Stereopsis**

Please advise your school nurse of any allergies or other pertinent medical history that your child may have.

Please contact your school's health office if you are having difficulty meeting these requirements. We look forward to meeting you and your child.

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NORTH READING PUBLIC SCHOOLS
NORTH READING, MASSACHUSETTS 01864

HEALTH HISTORY
(Grades Pre-K and K-5)

Please complete this questionnaire to the best of your ability and return it promptly to the school nurse. The information is for the confidential school medical record kept for each child, and is of great help to the school nurse and doctor in understanding and helping to safeguard your child's health.

Student's Name: _____ Sex: _____ Grade: _____
(First) (Middle) (Last)

Address: _____ Date of Birth: _____ Place of Birth: _____

Length of Residence: _____ Home Phone: _____ Primary Language: _____

Parent/Guardian 1: _____ Place of Birth: _____ Year of Birth: _____

Address: _____ Home Phone: _____

Occupation: _____ Business Address: _____

Business Phone: _____ Cell Phone: _____ State of Health: _____

Parent/Guardian 2: _____ Place of Birth: _____ Year of Birth: _____

Address: _____ Home Phone: _____

Occupation: _____ Business Address: _____

Business Phone: _____ Cell Phone: _____ State of Health: _____

Legal Guardian: _____ Phone Number: _____

Foster Parent: _____ Phone Number: _____

Name of Medical Doctor or Clinic: _____

Address: _____ Phone Number: _____

Name of Dentist: _____

Address: _____ Phone Number: _____

List below all other members in the household.

Name	Relationship	Date of Birth	Sex	Health

Please describe medical conditions of family members: _____

_____

Was there anything unusual about this pregnancy, labor or delivery? Yes ☐ No ☐

If yes, please explain. _____

Did the child have any difficulty at birth or shortly after birth? Yes ☐ No ☐

If yes, please explain. _____

Was the child premature? Yes ☐ No ☐ If yes, by how many weeks? _____ Birth weight: _____

Ever been hospitalized? Yes ☐ No ☐ If yes, for what reason: _____

When? _____ Where? _____ Duration of stay? _____

Ever had surgery? Yes ☐ No ☐ When? _____ For what? _____

Has the child ever had a serious accident? Yes ☐ No ☐

If Yes, please explain: _____

Please complete the back side of this form.

(over, please...)

Please describe any medical conditions your child has or has had in complete detail:

Skin (ex. eczema, psoriasis, persistent rash):
Yes ☐ No ☐ If yes, please describe: _____

Vision (ex. vision difficulties, turning in of the eyes, wearing glasses, color vision problem, visiting an eye doctor):
Yes ☐ No ☐ If yes, please describe: _____

Hearing (ex. hearing difficulties, ear infections, visiting an ear doctor):
Yes ☐ No ☐ If yes, please describe: _____

Nose, Mouth and Throat (nosebleeds, frequent colds, strep throat, tooth/gum problems):
Yes ☐ No ☐ If yes, please describe: _____

Respiratory (ex. asthma, persistent cough or wheeze, bronchitis, pneumonia, shortness of breath, tuberculosis):
Yes ☐ No ☐ If yes, please describe: _____

Cardiac (ex. heart murmur, congenital heart defect, rheumatic fever, palpitations, high blood pressure, high cholesterol):
Yes ☐ No ☐ If yes, please describe: _____

Gastrointestinal (ex. food intolerance, difficulty swallowing, reflux, vomiting, constipation, diarrhea, hernia):
Yes ☐ No ☐ If yes, please describe: _____

Urinary (ex. difficulty urinating, pain on urination, wetting problems, urinary tract infections, kidney problems):
Yes ☐ No ☐ If yes, please describe: _____

Orthopedic (ex. walking problems, decreased strength/movement, joint pain, fracture, dislocation, scoliosis, orthotic devices):
Yes ☐ No ☐ If yes, please describe: _____

Neurological (ex. headache, dizziness, fainting, seizures, tics, tremors, head injury, meningitis, hypotonia, cerebral palsy):
Yes ☐ No ☐ If yes, please describe: _____

Endocrine (ex. diabetes, thyroid, hormone disorder):
Yes ☐ No ☐ If yes, please describe: _____

Blood (ex. bleeding disorder, anemia, treatment for elevated lead level, excessive bruising, blood transfusion):
Yes ☐ No ☐ If yes, please describe: _____

Developmental (ex. trouble reaching milestones, learning problems, language, social skills, gross/fine motor):
Yes ☐ No ☐ If yes, please describe: _____

Social (ex. Attention Deficit, Persistent Developmental Disorder, autism, anxiety, depression, behavioral, in therapy):
Yes ☐ No ☐ If yes, please describe: _____

Does your child have any other medical conditions? Yes ☐ No ☐
If yes, please describe: _____

Does your child have any activity limitations or restrictions? Yes ☐ No ☐
If yes, please describe: _____

Has your child experienced a traumatic life event? Yes ☐ No ☐
If yes, please describe: _____

Allergies Does your child have any allergies or sensitivities (medication, food, environment, latex)? Yes ☐ No ☐
If yes, please describe all allergies: _____
Any food your child should not eat? _____

Medications Please list all medications your child takes and the reasons for the medications: _____

_____

Is there any other information about your child that you would like to share with the school nurse?

_____

I give permission to the school nurse to share information relevant to my child's health condition with appropriate school personnel and emergency care providers when needed to meet my child's health and safety needs.

Signature: _____ Date: _____

Revised 4/26/2011