

Darien Public Schools • Administrative Offices

P.O. Box 1167 • Darien, Connecticut 06820-1167 • Tel. 203-656-7400 • Fax 203-656-3052

January 2010

Dear Parents:

Kindergarten registration will take place in Darien elementary schools in late January and early February. In order to be eligible to attend kindergarten in 2010-2011, children must be five years of age on or before January 1, 2011.

Registration is scheduled for two days in each of the elementary schools, as follows:

Ox Ridge School	January 25 & 26	Hindley School	February 2 & 3
Tokeneke School	January 27 & 28	Royle School	February 4 & 5
Holmes School	January 29 & February 1		

In order to facilitate the registration process, parents should follow the schedule below:

Last Names,	1 st day,	A-G	9:30 a.m. – 12:00 p.m.
		H-M	1:00 p.m. – 3:00 p.m.
	2 nd day,	N-S	9:30 a.m. – 12:00 p.m.
		T-Z	1:00 p.m. – 3:00 p.m.

If it is not possible for you to register your child on the scheduled day or at the scheduled time, please call the school secretary at the appropriate number below, then press “0” for the main office, to schedule a different time.

Hindley School – 655-1323	Royle School – 655-0044
Holmes School – 353-4371	Tokeneke School – 655-9666
Ox Ridge School – 655-2579	

Forms are attached which should be completed prior to registration. **Please bring completed forms with you.** In addition, you **must present** the following at time of registration:

child’s birth certificate immunization record proof of residency

A brief conference with the school nurse will be held. Parents who wish to arrange hearing and vision screening for their child may make an appointment at a later time.

Children need not be present at the registration.

Sincerely yours,

The Elementary School Principals:

Rita M. Ferri, Hindley School
MaryLee Fisher, Tokeneke School
Neal J. Gallub, Royle School

Geraldine A. Petrizzi, Holmes School
John F. Rechi, Ox Ridge School

FULL DAY KINDERGARTEN MEETING

Monday, January 25, 2010

7:00-8:30 P.M.

Snow Date: Wednesday, January 27th

Board of Education Meeting Room

Central Office, 2 Renshaw Rd.

Audience:

Parents of incoming kindergarten students who would want to learn more or have questions about the full day kindergarten program

Agenda:

- Overview of full day kindergarten schedule
- Outline of kindergarten instructional program
- Question and answer period

DARIEN PUBLIC SCHOOLS

Student Name: _____	Date of Entry: _____
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Student I.D.: _____ Grade: _____ Gender: _____ Birth date: _____
(9 digit Social Security Number) (2 digits only) (mm/dd/yy)

Last Name: _____ First Name: _____ Middle: _____

Address: _____
House # _____ Street _____ Apt. # _____

Home Phone: _____ Race: _____ (Race code explanation on back)

Birthplace: City: _____ State: _____ Zip: _____ Country: _____

Citizen Status: U.S. _____ Other _____ Specify: _____

Name of Previous School: _____

Address: _____ City: _____ State: _____ Zip: _____

Public? _____ Private? _____ Grade Completed: _____ Date: _____

Date of Entry into U.S. Schools _____

Father's Name: _____

(Marital Status: Married, Separated, Divorced, Widowed, Guardian) Legal Custody* _____

Address: _____ Phone: _____

City: _____ State: _____ Zip: _____ Cell: _____

Father's or Guardian's Firm or Occupation: _____

Business Address: _____ Phone: _____

Mother's Name: _____

(Marital status: Married, Separated, Divorced, Widowed, Guardian) Legal Custody* _____

Address: _____ Phone: _____

City: _____ State: _____ Zip: _____ Cell: _____

Mother's or Guardian's Firm or Occupation: _____

Business Address: _____ Phone: _____

*If separated or divorced, who has legal custody of this child?

*It is our policy to share information with both parents unless we are advised otherwise.

Dominant Language Information is required by state law. **PLEASE ANSWER ALL FOUR QUESTIONS:**

First language spoken by student: _____

Current language spoken by student: _____

Primary language spoken by parents: _____

Dominant language spoken in home: _____

NAME AND BIRTH DATE OF BROTHERS AND SISTERS UNDER 21 YEARS OF AGE

NAME	MO	DA	YR	NAME	MO	DA	YR
NAME	MO	DA	YR	NAME	MO	DA	YR
NAME	MO	DA	YR	NAME	MO	DA	YR

Emergency local contacts if neither parent can be reached:

1) Name: _____ Phone: _____ Cell: _____

2) Name: _____ Phone: _____ Cell: _____

3) Name: _____ Phone: _____ Cell: _____

Parent's/Guardian's Signature

ETHNIC CATEGORY INFORMATION IS REQUIRED BY STATE LAW

RACE CODE EXPLANATION KEY:

1	American Indian	A person having origins in any of the original peoples of North America.
2	Asian American	A person having origins in any of the original peoples of the Far East, Southeast Asia, or the Pacific Islands.
3	Black	Not of Hispanic origin. A person having origins in any of the Black racial groups.
4	White	Not of Hispanic origin. A person having origins in any of the original peoples of Europe, North Africa, the Middle East or the Indian Subcontinent.
5	Hispanic	A person of Mexican, Puerto Rican, Cuban, Central or South American, or other Spanish culture of origin, regardless of race.

For school use only:

Is Birth Certificate verified? Y _____ N _____ **witnessed by** _____

Is Residency verified? _____ **witnessed by** _____

Documentation Presented

KINDERGARTEN RELEASE FORM

I give permission to the _____
Please specify Name and Address of Pre-School

_____ to release information

about my child, _____
Name of Child Date of Birth

To the Darien Public Schools. This information will be used to facilitate placement of my child in kindergarten for the _____ school year. This release is valid for one year from the date signed.

Parent Name (please print)

Address

City State Zip Code

Parent Signature

Date

cc: Student File

4/26/04

DARIEN ELEMENTARY SCHOOLS
Parent Input Form

To assist the staff with placement consideration for your child, please take this opportunity to provide any pertinent information that will enable us to select the best learning atmosphere. We do not honor requests for specific teachers.

Personality and Social Development:

Strengths/Talents:

Areas Needing Support:

Other Pertinent Information:

Child's

Name _____ Boy ___ Girl ___ Age _____ D.O.B. _____

Nickname _____

Pre-school

attended _____

DIRECTORY INFORMATION

SCHOOL: _____

Child's Name: _____

Address: _____ Phone: _____

Mother's Name: _____

Father's Name: _____

E-Mail Address: _____

Please complete as you would like the listing to read in the school directory, and return to school at the time of registration.

2010-11 Darien School Calendar (Approved April 28, 2009)

July						
		1	2			
5	6	7	8	9		
12	13	14	15	16		
19	20	21	22	23		
26	27	28	29	30		

August (2)					
2	3	4	5	6	
9	10	11	12	13	
16	17	18	19	20	
23	24	25*	26*	27	
30	31				

*23 & 24 New Staff Orientation
25 & 26 Staff Development
27 Teacher Work Day
30 Students Return*

September (20)						
		1	2	3		
6	7	8	9	10		
13	14	15	16	17		
20	21	22	23	24		
27	28	29	30			

*6 Labor Day
9 Rosh Hashanah*

October (20)						
						1
		4	5	6	7	8
	11*	12	13	14	15	
	18	19	20	21	22	
	25	26	27	28	29	

11 Staff Development

November (19)						
1	2*	3	4	5		
8	9	10	11	12		
15	16	17	18	19		
22	23	24	25	26		
29	30•					

*2 ElectionDay/Staff Development
24 Early Dismissal
25&26 Thanksgiving Recess
30 Elementary Parent Conferences*

December (17)					
		1•	2•	3•	
6	7	8	9	10	
13	14	15	16	17	
20	21	22	23	24	
27	28	29	30	31	

*1-3 Elementary Parent Conferences
23 Early Dismissal
24-2 Holiday Recess
includes Christmas
Day & New Year's Day*

January (20)						
3	4	5	6	7		
10	11	12	13	14		
17	18	19	20	21		
24	25	26	27	28		
31						

*3 Students Return
17 Martin Luther King Jr.
Day*

February (15)						
		1	2	3	4	
7	8	9	10	11		
14	15	16	17	18		
21	22	23	24	25		
28						

*21-Presidents' Day
22-25 February Recess*

March (23)						
	1	2	3	4		
7•	8•	9•	10	11		
14	15	16	17	18		
21	22	23	24	25		
28	29	30	31			

7-9 Elementary Parent Conferences

April (15)					
					1
4	5	6	7	8	
11	12	13	14	15*	
18	19	20	21	22	
25	26	27	28	29	

*15 Staff Development
18-21 April Recess
22 Good Friday*

May (21)					
2	3	4	5	6	
9	10	11	12	13	
16	17	18	19	20	
23	24	25	26	27	
30	31				

30 Memorial Day

June (8)						
		1	2	3		
6	7	8	9	10		
13	14	15	16	17		
20	21	22	23	24		
27	28	29	30			

*10 School Ends for Students
13 Teacher Work Day*

Note #1: If schools are closed due to weather, additional days will be added to the end of the school year. Regarding High School Graduation, by State law, after April 1st, Boards of Education are permitted to establish a graduation date. Therefore, the Board of Education will make that determination at its first regular April, 2011 meeting.

Code:

- Early Dismissal (11/24, 12/23, 6/10)
- Early Dismissal for Elementary Schools Only (11/30, 12/1, 12/2, 12/3, 3/7, 3/8, 3/9)
- * Staff Development Days – No School for Students
- No School: Holidays and Vacations

Darien Public Schools * Health Services
80 High School Lane * Darien, CT 06820 * Tel. 203-655-3981 x 2304

January 2010

Dear Parent of Kindergarten Student to be enrolled in Darien Public Schools 2010-2011:

We welcome you and your child to the Darien Public School System. Below are the Connecticut State and Darien Board of Education requirements you must comply with before your child may start school. These measures are for the health and safety of all students. All students entering Kindergarten must have a physical examination before they may enter school per Connecticut law (P.A. 94-103, Section 10-206). A student will not be admitted in the Darien Public Schools until a school nurse has reviewed the new entrant's completed health assessment and immunization records.

For this coming year, the physical examination can be dated no earlier than August 31, 2009 (365 days prior to entrance on 8/30/10).

The physical examination must include:

A health history	Height and weight	Vision and hearing screenings
Blood pressure screening	Hematocrit / hemoglobin test	Gross dental screening
Scoliosis screening	Up-to-date Immunizations Record must meet Connecticut State immunization requirements.	

It is recommended that an assessment be made of the risk of exposure to tuberculosis. If the child is at high risk, a Tuberculosis Skin Test is required with the health examination. In addition, students originally from high risk countries that are entering CT schools for the first time, must receive a Tuberculosis Skin Test.

The new entrant must submit documentation of complete up-to-date immunization at the time of entry into the Darien Public School System in accordance with state law C G S 10-204a and the State of CT Department of Public Health Immunization Requirements for Students in Connecticut Public Schools. Please note at the time of the printing of this letter, the CT Department of Public Health has not published the updated immunization requirements for the 2010-2011 school year. Please find enclosed the CT Department of Public Health Immunization Requirements for Kindergarten Entry during the 2009-2010 school year. Please review the immunization requirements with your health care provider.

Exceptions to the school entrance immunization requirements:

1. Certificate from your physician stating the medical reason an immunization is contraindicated for the child. .
2. A statement from the parent or guardian that such immunizations are contrary to the child's religious beliefs.

The physical examination for Kindergarten students should be documented on the State of Connecticut Department of Education Health Assessment Record. (The blue health form or its equivalent) Physical examinations performed outside the United States are only accepted if done by a health care provider licensed to practice in the United States. Please submit the completed State of Connecticut Department of Education Health Assessment Record and Pre-Kindergarten Health and Developmental History form to your school's nurse prior to school entry.

Sincerely,

Ellen Ryan RN

Ellen Ryan, RN, MPH
Director of School Health Services
203-655-3981 x 2304 eryan@darienps.org



State of Connecticut Department of Education Health Assessment Record



To Parent or Guardian:

In order to provide the best educational experience, school personnel must understand your child's health needs. This form requests information from you (Part I) which will also be helpful to the health care provider when he or she completes the medical evaluation (Part II).

State law requires complete primary immunizations and a health assessment by a legally qualified practitioner of medicine, an advanced practice registered nurse or registered nurse, a physician assistant or the school medical advisor prior to school entrance in Connecticut (C.G.S. Secs. 10-204a and 10-206). An immunization update and additional health assessments are required in the 6th or 7th grade and in the 9th or 10th grade. Specific grade level will be determined by the local board of education.

Please print

Name of Student (Last, First, Middle)		Birth Date	Sex
Address (Street)		Race/Ethnicity <input type="checkbox"/> American Indian <input type="checkbox"/> White, not of Hispanic origin <input type="checkbox"/> Asian <input type="checkbox"/> Hispanic/Latino <input type="checkbox"/> Black, not of Hispanic origin <input type="checkbox"/> Other	
(Town and ZIP code)			
Home Telephone Number	School	Grade	
Name of Parent/Guardian (Last, First, Middle)			
Health Care Provider		Health Insurance Company/Number* or Medicaid/Number*	

* If applicable

If your child does not have health insurance, call 1-877-CT-HUSKY

Part I — To be completed by parent

**Important: Complete Part I before your child is examined.
Take this form with you to the health care provider's office.**

Please check answers to the following questions in columns on the left.
(Explain all "yes" answers in the space provided below.)

- | | Yes | No | |
|-----|--------------------------|--------------------------|--|
| 1. | <input type="checkbox"/> | <input type="checkbox"/> | Do you have any concerns about your child's general health (overall eating and sleeping habits, teeth, etc.)? |
| 2. | <input type="checkbox"/> | <input type="checkbox"/> | Has your child been diagnosed with any chronic disease? <input type="checkbox"/> asthma <input type="checkbox"/> diabetes <input type="checkbox"/> seizure disorder <input type="checkbox"/> other _____ |
| 3. | <input type="checkbox"/> | <input type="checkbox"/> | Does your child have any allergies (food, insects, medication, latex, etc.)? |
| 4. | <input type="checkbox"/> | <input type="checkbox"/> | Does your child take any medications (daily or occasionally)? |
| 5. | <input type="checkbox"/> | <input type="checkbox"/> | Does your child have any problems with vision, hearing or speech (glasses, contacts, ear tubes, hearing aids)? |
| 6. | <input type="checkbox"/> | <input type="checkbox"/> | Has your child had any hospitalization, operation, major illness or injury, or significant accident? (Please specify.) |
| 7. | <input type="checkbox"/> | <input type="checkbox"/> | In the last 12 months, has your child experienced any difficulty with wheezing, excessive coughing or excessive night waking? (Please specify.) |
| 8. | <input type="checkbox"/> | <input type="checkbox"/> | In the last 12 months, has your child experienced any difficulty with excessive weight loss or weight gain, or excessive thirst or urination? (Please specify.) |
| 9. | <input type="checkbox"/> | <input type="checkbox"/> | Does your child have health insurance? (If your child does not have health insurance, call 1-877-CT-HUSKY) |
| 10. | <input type="checkbox"/> | <input type="checkbox"/> | Does your child have dental insurance? |
| 11. | <input type="checkbox"/> | <input type="checkbox"/> | Would you like to discuss anything about your child's health with the school nurse? |

Please explain any "yes" answers here. For illnesses/injuries/etc., include the year and/or your child's age at the time.

I give permission for release of information on this form for confidential use in meeting my child's health and educational needs in school.

Signature of Parent/Guardian

Date

To the Health Care Provider: Please complete and sign.

_____ has had a complete history and physical exam on _____
 Student's Name Birth Date Month/Day/Year

Findings for this student are as follows:

Screening/Test Results			Immunization Record							
Note: * Mandated Screening/Test under Connecticut State Law										
* Height:		BMI:	Vaccine (Month/Day/Year) Note: * Minimum requirements prior to school enrollment. At subsequent exams, note booster shots only.							
* Weight:		* Postural:	Dose 1	Dose 2	Dose 3	Dose 4	Dose 5	Dose 6		
* Blood Pressure:		<input type="checkbox"/> Normal	DTP	*	*	*	*			
Pulse:		<input type="checkbox"/> Abnormal	DTP/Hib							
* HCT/HGB:		Min. _____	DTaP							
Urinalysis:		Slight _____	DT/Td							
* Gross dental:		Mod. _____	OPV	*	*	*				
Lead (Date/Result)		Marked _____	IPV	*	*	*				
		<input type="checkbox"/> Referral	MMR							
TB and Other Test Results (Sickle Cell, etc.)			Measles	*	*			Booster for entry into K and 7th grade		
TB: In high-risk group? <input type="checkbox"/> Yes <input type="checkbox"/> No			Mumps	*						
Test	Date	Results	Rubella	*						
			HIB	*				Students under age 5		
			Hep B	*	*	*		Req. for entry into K and 7th grade.		
* Vision/ Type of Screening		* Auditory/ Type of Screening	Varicella	*				Students born 1/1/97 or later. Required for 7th grade entry.		
With glasses	R L	Pass/Fail	PCV					Pneumococcal conjugate vaccine		
	20/ 20/	R	Other Vaccines (Specify)							
Without glasses	R L	L								
	20/ 20/									
* Chronic Disease Assessment:			Disease Hx of above _____ (Specify) _____ (Date) _____ (Confirmed by) Exemption Religious _____ Medical: Permanent _____ Temporary _____ Date _____ Recertify Date _____ Recertify Date _____ Recertify Date _____							
Yes No										
<input type="checkbox"/> <input type="checkbox"/> Asthma: <input type="checkbox"/> mild <input type="checkbox"/> moderate <input type="checkbox"/> severe <input type="checkbox"/> exercise induced <input type="checkbox"/> unclassified _____										
<input type="checkbox"/> <input type="checkbox"/> Diabetes: <input type="checkbox"/> Type I <input type="checkbox"/> Type II _____										
<input type="checkbox"/> <input type="checkbox"/> Anaphylactic Reaction: <input type="checkbox"/> food <input type="checkbox"/> insect <input type="checkbox"/> latex _____										
<input type="checkbox"/> <input type="checkbox"/> Seizure Disorder _____ <input type="checkbox"/> <input type="checkbox"/> Other: Please specify _____										
Date of onset _____										

This student has the following problems which may adversely affect his or her educational experience:

- Vision Auditory Speech/Language Physical Dysfunction Emotional/Social Behavior
- The pupil has a health condition which may require emergency action at school, e.g., seizures, allergies, anaphylaxis. *Specify below.*
- The pupil is on long-term medication. *Specify below.*

Comments and recommendations (additional information about any of the above health assessment): _____

- This student may participate fully in the school program, including physical education activities.
- This student may participate in the school program and physical education with the following restriction/adaptation. *(Specify reason and restriction.)* _____

- Yes No Based on this comprehensive health history and physical examination, this student has maintained his/her level of wellness.
- I would like to discuss information in this report with the school nurse.

Signature of health care provider	Name/Group Practice (Please type or print.)	Phone Number
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Does Your Child Have Health Insurance?

Connecticut's HUSKY Plan offers low-cost or free health care

Dear Parent/Guardian,

Is your child protected by health insurance? If not, your school and the State of Connecticut want to help. Please fill out this form and return it to your child's teacher, school nurse or school office. The school will then contact Connecticut's HUSKY Plan to help connect your student with health insurance coverage.

Healthy kids do well in school! HUSKY pays for doctor visits (including physical exams), prescriptions, emergency care, vision and dental care, mental health care, special health care needs and more. It's for children under age 19 in families of all incomes. Over 230,000 children now have their health care covered by the HUSKY Plan.

If your child is uninsured and you would like to participate in Connecticut's HUSKY Plan, please fill out and return this form to your child's teacher, school nurse, or school office. Your signature means that the school can provide your contact information to the Connecticut Department of Social Services (administering agency of the HUSKY Plan) or its enrollment contractor so that a HUSKY customer service representative may call you, send you an information kit, and begin the application process to insure your child's health.

Parent/guardian's name (please print): _____

Parent/guardian's signature: _____

Street address: _____

City or town: _____, CT Zip code: _____

Name(s) and age(s) of uninsured child(ren): _____

Best phone number for the HUSKY representative to call you at? (area code first): () _____

If you want an information & application kit sent to you, please check here:

OR: If you want to find out more information on HUSKY right away, call the HUSKY information hotline--1-877-CT-HUSKY (1-877-284-8759).

Hours are 8:30 a.m.-8 p.m. Monday-Thursday; 8:30 a.m.-6 p.m. Friday; and 10 a.m.-2 p.m. Saturday. You can apply by phone or request an information kit.

OR: Visit HUSKY at www.huskyhealth.com. Check out our colorful website & download the application.

This partnership of Connecticut schools and the HUSKY Plan is from the HUSKY enrollment initiative proposed by Governor M. Jodi Rell and approved by the General Assembly in Section 119 of Public Act 07-02, June Special Session. Special thanks to the Connecticut Department of Education, Connecticut Department of Social Services, Regional Education Service Centers, and all caring school personnel throughout the state as we join with parents to bring health coverage to all Connecticut children.

STATE OF CONNECTICUT

DEPARTMENT OF PUBLIC HEALTH



IMMUNIZATION REQUIREMENTS FOR NEWLY ENROLLED STUDENTS AT CONNECTICUT SCHOOLS 2009-2010 SCHOOL YEAR



Kindergarten:

DTaP:	At least 4 doses. The last dose must be given on or after 4 th birthday
Polio:	At least 3 doses. The last dose must be given on or after 4 th birthday
MMR:	1 dose on or after the 1 st birthday
Measles:	Second dose of measles vaccine (or MMR), given at least 4 weeks after the first dose
Hib:	Children less than 5 yrs of age need 1 dose at 12 months or older Children 5 and older do not need proof of Hib vaccination
Hep B	3 doses
Varicella	1 dose on or after the 1st birthday or verification of disease

Important Reminders:

- DTaP vaccine is not given on or after 7th birthday
- DTaP may be given for all doses in the primary series
- Tdap should be given in lieu of Td vaccine for children 10 years and older unless contraindicated. Tdap is only licensed for one dose.
- Hib is not given or required for children 5 years of age or older
- Hep B requirement for school year 2009-2010 applies to all students in grades K-12
Spacing intervals for a valid Hep B series are at least 4 weeks between dose #1 and dose #2; 8 weeks between dose #2 and dose #3; at least 16 weeks between dose #1 and dose #3; dose #3 should not be given before 24 weeks of age.
- Second measles (or MMR) for school year 2009-2010 applies to all students in grades K-12
- Varicella requirements went into effect for any child born on or after 1/1/1997 **and** for students entering 7th grade after August 2000. For 2009-2010, this requirement applies to all students in grades K-12.
- Laboratory confirmation of immunity is **only** acceptable for Hepatitis B, Measles, Mumps, Rubella, and Varicella

New Entrant Definition:

*New entrants are any students who are new to the school district, including preschoolers and all students coming in from Connecticut private, parochial and charter schools located in the same or another community. All students entering kindergarten, including those moving from any public or private pre-school program, even in the same school district, are considered new entrants. The one exception is students returning from private approved special education placements – they are not considered new entrants.

Please note: The CT Department of Public Health has not published the updated Immunization Requirements for the 2010 - 2011 school year. Please check the school website and with your health care provider for updated school entry immunization requirements for the 2010-2011 school year.

DARIEN PUBLIC SCHOOLS

Darien, Connecticut

PRE-KINDERGARTEN HEALTH AND DEVELOPMENT HISTORY

(To Be Completed by Parent)

Dear Parents:

Soon your child will begin his/her school life. Until now, your child's life has been centered in your home, where you have been preparing him/her in many ways. You know your child because he/she has been entirely yours for this time. You have seen your child grow from infancy to childhood. You have encouraged and helped your child to grow up.

We know about children in general, because of our training and experience, but we do not yet know your child. In order that we may provide the best educational experience and the best possible care for any emergency which may arise while your child is in school, school personnel must understand your child's health needs. By answering the questions on the following three pages, you will help us to better know your child as an individual.

PLEASE BRING THIS COMPLETED FORM TO THE SCHOOL NURSE ON THE DAY OF REGISTRATION.

DARIEN PUBLIC SCHOOLS
DARIEN, CONNECTICUT
KINDERGARTEN HEALTH AND DEVELOPMENT HISTORY
(To be completed by Parent)

I. IDENTIFICATION DATA

Child's Name _____ Sex: F M
Last First Middle Circle

Birth date: _____ Birthplace _____
Mo. Day Year

Address: _____ Tel No. _____

Mother's Name: _____ Father's Name: _____

II. CHILD'S DEVELOPMENT

Birth History

Pregnancy history: _____
Delivery history: _____
Gestational age: _____
Apgar score: _____
Hours of labor: _____
Complications: _____
Birth Weight: _____

Family History:

How many brothers and sister does child have?
Younger: _____
Older: _____
Twin: _____

Who lives in the house with your child?

Parents: _____
Brothers: _____
Sisters: _____
Others: _____

Significant family health concerns impacting child's school experience: _____

Child's Preschool Developmental History:

Height or Weight (growth) concerns: _____

Age child:

Sat: _____
Walked: _____
Toilet trained: _____
Spoke several words (apart from "ma" and "da"):

Spoke short sentences: _____
Spoke complete sentences: _____

Can you understand your child's speech?

Yes _____ No _____

Does your child get frustrated when he is not easily understood? Yes _____ No _____

Does your child rely on speech or gestures for communication? _____

Are you concerned about your child's speech?

Yes _____ No _____

Is there a family history of a speech problem or hearing loss? Yes _____ No _____

Can your child take care of himself in the bathroom?

Yes _____ No _____ What assistance is necessary?

Does your child need assistance with dressing?

Yes _____ In what way? _____ No _____

How much experience has your child had in playing with other children of his own age group?

Little _____ Average _____ A great deal _____

Has your child attended pre-school? Yes _____ No _____

If yes, how many years?

Name of Pre School(s):

THE FOLLOWING ARE COMMON CHARACTERISTICS OF A CHILD'S DEVELOPMENT.
PLEASE CHECK THOSE WHICH ARE STILL PRESENT.

- | | |
|------------------------------|--|
| 1. _____ sleep disturbances | 10. _____ fears |
| 2. _____ problems of eating | 11. _____ excessive shyness |
| 3. _____ quiet and withdrawn | 12. _____ excessive jealousy |
| 4. _____ easily frustrated | 13. _____ marked aggressive behavior |
| 5. _____ temper tantrums | 14. _____ nervousness |
| 6. _____ thumb sucking | 15. _____ daydreaming |
| 7. _____ nail biting | 16. _____ physical coordination difficulty |
| 8. _____ bed wetting | 17. _____ separation anxiety |
| 9. _____ soiling | 18. _____ other |

AT WHAT AGE DID ANY OF THE FOLLOWING OCCUR?

- | | |
|--|--|
| 1. _____ 4 or more colds each year | 15. _____ unexplained bruise marks |
| 2. _____ frequent sore throats | 16. _____ posture problems (spine or feet) |
| 3. _____ persistent cough | 17. _____ night sweats |
| 4. _____ ear infections | 18. _____ tires easily |
| 5. _____ frequent headaches | 19. _____ shortness of breath |
| 6. _____ fainting | 20. _____ convulsions (seizures) |
| 7. _____ dizzy spells | 21. _____ hyperactive |
| 8. _____ frequent sties/other eye conditions | 22. _____ tendency to forget |
| 9. _____ frequent nose bleeds | 23. _____ thyroid deficiency |
| 10. _____ abdominal pain | 24. _____ trouble stopping small cuts bleeding |
| 11. _____ hernia (rupture) | 25. _____ weight problem |
| 12. _____ stomach upsets | 26. _____ hay fever or hives |
| 13. _____ frequent constipation | 27. _____ other (specify) _____ |
| 14. _____ aches,swelling,stiffness in joints/muscles | |

LIST NUMBER OF ABOVE ITEMS WHICH ARE PRESENT NOW: _____

COMMENTS: _____

III. DISEASE AND ILLNESS HISTORY:

<u>Check</u>	<u>Year if Known</u>	<u>Check</u>	<u>Year if Known</u>
_____	_____	_____	_____
Anemia _____	_____	Kidney/Bladder Problems _____	_____
Asthma _____	_____	Lyme Disease _____	_____
Bronchitis _____	_____	Measles _____	_____
Congenital Defects _____	_____	Mumps _____	_____
Cerebral Palsy _____	_____	Pneumonia _____	_____
Chicken Pox _____	_____	Poliomyelitis _____	_____
Diabetes _____	_____	Rheumatic Fever _____	_____
Eczema _____	_____	Scarlet Fever _____	_____
Epilepsy _____	_____	Strep Throat _____	_____
Fifths Disease _____	_____	Tonsillitis _____	_____
German measles (Rubella) _____	_____	Tuberculosis _____	_____
Heart Disease of Defects _____	_____	Whooping Cough _____	_____
Hepatitis _____	_____	Other (specify) _____	_____
Impetigo _____	_____		

IV. HEALTH HISTORY

Child's Physician: _____

Does your child take medication on a regular basis? Yes _____ No _____

Name of medication _____

Frequency taken _____

Reason _____

Are there any limitations on your child's physical activity? Yes _____ No _____

Explain: _____

Does your child have any allergies? If so, Please list:

Life threatening: _____

Other: _____

Reaction: _____

(e.g. hives, swelling, rash, breathing difficulty, etc.)

Current treatment: _____

Doctor's name: _____

Has your child ever had any serious accidents? Y ___ N ___

Describe and give dates: _____

Has your child ever been hospitalized? _____

When? _____ Reason: _____

Additional comments: _____

Parent Signature: _____

Date: _____

Has your child ever had an eye examination?

Yes _____ No _____

Date: _____

Findings: _____

Doctor's name: _____

Does your child wear glasses? Yes _____ No _____

If yes, since when? _____

And when are they to be worn? _____

Has child ever had a hearing problem? Yes ___ No ___

Explain: _____

Has child ever had a hearing test? Yes _____ No _____

By whom? _____

Date and findings _____

Has child ever been to a dentist? Yes _____ No _____

Was dental care completed? Yes _____ No _____

Does child receive regular dental care? Yes ___ No ___

Dentist's name: _____

Would you like to meet with the school nurse to discuss anything about your child's health? _____
