BEAVERCREEK CITY SCHOOL DISTRICT
Pupil Services Department
3040 Kemp Road
Beavercreek, OH 45431
Phone: 458-2414 Fax: 458-2432

STUDENT HEALTH SCREENING CHECKLIST

(Use with all preschoolers, kindergartners and new first graders.)

Please complete the form below in order to help the school staff to better understand your child. Place a check beside items which describe your child most of the time.

Child's Name ____Date of Birth _______________
First Middle Last Month/Day/Year

Nickname (if any): ____

Father's Name ______________________________________ Mother's Name ____________________________________
First Last First Last

With whom does child live? ____
Name Relationship

Address ____ Home Phone ______________________

Who is this child's legal guardian? ____

Below, please list this child's brothers and sisters (if any):

Name	Birth year	Gender
1. School Attending:		
2. School Attending:		
3. School Attending:		

DEVELOPMENTAL HISTORY

1. Did the mother have any unusual physical or emotional illnesses during this pregnancy? ____ Yes ____ No

2. How old was the mother when this child was born? ________________

3. Was the infant born full term? ____ Yes ____ No If not, how early or late? _________________________________

4. What was the infant's birth weight? _____________________________

5. Did the infant have any sickness or problems while in the nursery? ____ Yes ____ No

6. If yes to above, please briefly explain: ____

7. Please give the approximate age at which this child did the following:
   - Walked alone _________
   - Was toilet trained _________
   - Spoke in sentences _________
   - Dressed self _________

8. How does this child's development compare to other children, such as his/her playmates or siblings? Check Box.
   - ☐ About the same
   - ☐ Slower
   - ☐ Faster

*** OVER ***

DEVELOPMENTAL: Please check applicable items listed below:

_____ Plays well with other children
_____ Prefers to play alone
_____ Gets along well with adults
_____ Is shy
_____ Shares willingly
_____ Has temper tantrums
_____ Has a good appetite
_____ Eats a variety of foods
_____ Has some specific fears
Specific Fear: ____________________________
_____ Has a good attitude toward entering school
_____ Dresses self
_____ Attended Preschool - How Long:_____________
_____ Where: _________________________________

_____ Tires easily
_____ Is not toilet trained
_____ Sucks thumb
_____ Talks easily and willingly
_____ Knows full name
_____ Uses scissors
_____ Has been read to
_____ Reads some words
_____ Reads with little or no assistance
_____ Usually uses right hand
_____ Can follow simple directions
_____ Can put together simple puzzles
_____ Has speech problems

HEALTH CONDITIONS - Please check all that apply:

_____ Abnormal spinal curvature (scoliosis, etc.)
_____ Allergies or hay fever
_____ Anemia
_____ Arthritis
_____ Asthma or wheezing
_____ Bedwetting at night
_____ Behavior problem
_____ Birth or congenital malformation
_____ Cancer, type ______________________________
_____ Chicken pox
_____ Chronic diarrhea or constipation
_____ Concern about relationship with siblings or friends
_____ Cystic fibrosis
_____ Diabetes
_____ Ear Problems
_____ Eczema
_____ Emotional problems
_____ Eye problems, poor vision
_____ Frequent headaches

_____ Frequent skin infections
_____ Frequent sore throat infections
_____ Heart disease, type ___________________________
_____ Hepatitis
_____ Kidney disease, type __________________________
_____ Measles ("old fashioned" or "ten day")
_____ Meningitis or encephalitis
_____ Multiple ear infections (3 or more)
_____ Mumps
_____ Near-drowning or near-suffocation
_____ Nervous twitches or tics
_____ Poisoning
_____ Rheumatic fever
_____ Seizures or epilepsy
_____ Sickle cell disease
_____ Stool soiling
_____ Toothaches or dental infections
_____ Urinary tract infection
_____ Wetting during day

ALLERGIES: Please list and describe allergies or reactions to:
Medicines/drugs ____
Foods/plants/animals/other ____
Recommended treatment if allergy is severe ____

INJURIES AND ILLNESSES: Please list any severe injuries or illnesses:

Injuries/Illnesses	Age of Child	If Hospitalized (check)

ADDITIONAL INFORMATION:
What medications are given daily? ____
What medications are given frequently, but not daily? ____
********* PLEASE NOTE: In order to administer medication at school, there must be a Beavercreek Schools Medication form on file.**

This child is usually: very active __________ normally active __________ rather inactive __________

Do you have any concern about how your child gets along with other children? ____

Completed by: ____

Relationship to Child: _____________________________________

Today's Date: __________________________________ *Thank you for your cooperation.*

Revised 2/5/13
g25/vlk