Key West
Early Childhood Center

MEDICAL HISTORY

Child's Name_____ DOB_____ Today's Date_____

1. Was your child premature? ❒ Yes ❒ No Birth Weight_____
2. Has your child had eye/vision problems? ❒ Yes ❒ No If yes, explain_____
3. Has your child had an eye exam? ❒ Yes ❒ No Doctor_____ Last Exam Date_____
4. Does your child wear glasses? ❒ Yes ❒ No Doctor recommendation_____
5. Has your child had ear problems? ❒ Yes ❒ No If yes, explain_____
6. Has your child had "tubes" in ears? ❒ Yes ❒ No If yes, date_____
   "Tubes" still in place? ❒ Yes ❒ No
7. Has your child had teeth problems? ❒ Yes ❒ No If yes, explain_____
8. Date of last dental exam? ❒ Yes ❒ No Dentist Name_____
9. Has your child had any speech problems? ❒ Yes ❒ No If yes, explain_____
10. Child currently receiving speech services? ❒ Yes ❒ No
11. Has your child ever had seizures? ❒ Yes ❒ No
    If yes, explain_____ Last Seizure Date _____
12. Is he/she on seizure medication?? ❒ Yes ❒ No If yes, please list medication_____
13. Has your child had any heart condition? ❒ Yes ❒ No If yes, explain_____
14. Has your child had heart surgery? ❒ Yes ❒ No If yes, explain _____
15. Does your child have asthma? ❒ Yes ❒ No If yes, is he/she on medication? ❒ Yes ❒ No
    Will medication be required at school? ❒ Yes ❒ No
16. Does your child have any problems eating? ❒ Yes ❒ No If yes, explain_____
17. Does child have bladder/bowel problems? ❒ Yes ❒ No If yes, explain_____
18. Does child have a current serious illness? ❒ Yes ❒ No If yes, explain_____
19. Does child have any orthopedic concerns? ❒ Yes ❒ No If yes, explain_____
20. Any past/future operations? ❒ Yes ❒ No If yes, explain and provide dates _____
    _____
21. Any injuries requiring stitches or a cast? ❒ Yes ❒ No If yes, explain_____
22. Has your child had chicken pox? ❒ Yes ❒ No If yes, when_____
23. Has Keystone evaluated your child? ❒ Yes ❒ No
    If so, when_____, and what were the recommendations_____
    _____
24. Does your child have any allergies?? ❒ Yes ❒ No
    If yes, please list (include food, meds., environment) _____
    What is allergic response? _____
    Are medication's given for reaction? ❒ Yes ❒ No
    Please list medications_____ Will medication need to be kept at school? ❒ Yes ❒ No
25. Please list any other medication's your child takes regularly_____
26. Is your child (please check all that apply) ❒ Unusually Shy ❒ Quiet ❒ Sensitive?
27. Does your child (please check all that apply) ❒ Cry Easily ❒ Overactive ❒ Have temper tantrums?
28. Has child previously attended preschool/childcare? ❒ Yes ❒ No If yes, where?_____

❒ I agree that this information can be released to school personnel who need to know.

Parent Signature_____ Date _____