Algonac Community Schools

PARENTS' REPORT

Note: This form is to be filled out by the parent and brought to Kindergarten Introduction Day.

Please complete prior to physical examination by physician:

Child's Name_____ Birthdate_____

Parent/Guardian Name _____ Phone _____

Address_____

Physician _____ Address _____ Phone _____

Dentist _____Address _____ Phone _____

Date of last visit to the dentist _____

Birth & Infancy information (approximate age): Full Term? _____ Birth weight: _____

Toilet Trained at _____ Walked at _____ Spoke first words at _____

Previous Illnesses (give age of occurrence:

Measles _____	**Mumps** _____	**Enlarged Lymph Glands** _____	**Tonsillitis** _____
Asthma _____	**Epilepsy** _____	**Chicken Pox** _____	**Whooping Cough** _____
Scarlet Fever _____	**Rheumatic Fever** _____	**Infantile Paralysis** _____	**German Measles** _____
Eczema _____	**Ear Infection** _____	**Kidney Disease** _____	**Appendicitis** _____
	Hay Fever _____	**Bone/Joint Disease** _____	**Other** _____

Has your child had any of the following symptoms recently?

Frequent colds _____	**Dizziness** _____	**Growing Pains** _____	**Headaches** _____
Hard of hearing _____	**Blurred vision** _____	**Vomiting spells** _____	**Hernia** _____
Chronic constipation _____	**Abdominal pains** _____	**Frequent urination** _____	**Nosebleed** _____
Persistent cough _____	**Fainting spells** _____	**Shortness of breath** _____	

Operations:

Tonsils Age _____

Adenoids Age _____

Appendix Age _____

Circumcision Age _____

Other Age_____

Serious Injuries (cause, nature, age):

1. _____

2. _____

3. _____

4. _____

- What time does he/she go to bed? _____
- What time does he/she get up? _____
- Does he/she take naps? _____
- Does he/she eat well? _____ At all meals? _____
- Does your child have any trouble hearing? _____yes _____no _____don't know
- Does he/she have earaches? _____yes _____no _____don't know
  - If yes, how many earaches has he/she had in the past 12 months? _____
  - When did he/she have the last earache? _____
  - Did he/she see a medical doctor concerning the earache(s)? _____yes _____no
- Has your child had his/her hearing tested through preschool Vision and Hearing or have you made an appointment for this?

  _____yes _____no
- Has your child had his/her eardrums opened, lanced or had tubes inserted? _____yes _____no
- Has your child ever had a runny ear or any discharge from his/her ear (not including wax in the ears)?

  _____yes _____no
- Does your child "hear" better when watching the speaker's face? _____yes _____no
- Does your child often ask for words or sentences to be repeated? _____yes _____no

Parent Signature _____ **Date**_____