

**St. Paul the Apostle School**  
**Preschool Health Record**  
**2011-2012**

Last name of Student \_\_\_\_\_ First Name of Student \_\_\_\_\_

Grade \_\_\_\_\_ Homeroom teacher \_\_\_\_\_

Names of parents or guardians \_\_\_\_\_

Family Doctor \_\_\_\_\_ Phone \_\_\_\_\_

Family Dentist \_\_\_\_\_ Phone \_\_\_\_\_

Lead test (children age 6 years or under) Date _____ Result _____
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Please circle yes or no:

YES NO Is your child allergic to medication, food, bee stings, or environmental allergens?  
If yes, list name and reaction \_\_\_\_\_

YES NO Does your child take medication (s) on a routine basis?  
If yes, list name and times taken \_\_\_\_\_

YES NO Does your child have a medical diagnosis of a chronic health condition such as diabetes, asthma, heart problems, seizures, etc?  
If yes, list condition \_\_\_\_\_

Please list any additional health related concerns that you would like to have reviewed by the Scott County Health Department nurse:

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This document is used for evaluating the physical and emotional condition of each student to meet the student's health needs. This health information may be shared with the school and health staff for the purpose of meeting student health and learning needs.

Parent / Guardian signature \_\_\_\_\_ Date \_\_\_\_\_

<p>The following individuals are authorized to have access to health information: Student's teacher and teachers' aides, School Secretaries, School's nurse representative from Scott County Health, school principal, School Psychologist.</p> <p>Parent / Guardian signature _____ Date _____</p>
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