HEALTH REPORT for
KINDERGARTEN and NEW ENROLLMENT

EDGARTOWN SCHOOL

Today's Date: _____

CHILD'S FULL NAME: _____
(last name) (first name) (middle name)

DATE OF BIRTH: _____ SEX: _____

CHILD'S DOCTOR: _____ TELEPHONE: _____
CHILD'S DENTIST: _____ TELEPHONE: _____

MEDICAL HISTORY:

Birth weight _____lbs. _____oz. Complications during pregnancy _____

Asthma	_____	Epilepsy	_____	
Birth defects	_____	Heart disease	_____	
Diabetes	_____	Kidney disease	_____	
Ear infections	_____	Chicken pox	_____	date _____

Allergies _____
Convulsions & cause _____

Operations/hospitalizations:

Tonsils	_____	date_____
Adenoids	_____	date_____
Appendix	_____	date_____
Hernia	_____	date_____
Ear Tubes	_____	date_____

Accidents, broken bones, head injuries (with details and dates):

_____

_____

Other information:

Bed wetting _____ Wetting/soiling during the day _____
Pills, medicines and/or injections which give child a reaction _____
Foods your child is allergic to _____

Preschool / Nursery School attended & dates: _____

Previous School Experience: _____ Dates: _____

Other important information:

_____

_____

_____

MEDICAL HISTORY AND DATES (Ficha Medica, vacinas e dates)

Student's Name (Nome do estudante) _____

Chicken pox (Catapora)_____ Date (Data) _____
Congenital abnormality (Congenital abnormality) _____ Date (Data)_____
Ear Infections (Infecçaõ dos ouvidos_____ Date (Data)_____
Encephalitis (Encephálitis)_____ Date (Data)_____
German measles (Sarampo)_____ Date (Data)_____
Heart disease (Problema do coração)_____ Date (Data)_____
Kidney disease (Problema do rins)_____ Date (Data)_____
Measles (Measles) _____ Date (Data)_____

Meningitis (Meningite)_____ Date (Data)_____
Mumps (Mumpos) _____ Date (Data)_____
Polio (Polio) _____ Date (Data)_____
Rheumatic fever (Febre de reumatismo)_____ Date (Data)_____
Scarlet fever (Febre Scarlate)_____ Date (Data) _____
Strep throat (Infecção de garganta)_____ Date (Data)_____
Tonsillitis (Tonsillitis)_____ Date (Data)_____
Tuberculosis (Tuberculose)_____ Date (Data)_____
Whooping cough (Whooping cough)_____ Date (Data) _____

Does your child have? (Tem a sua criança?)

Has your child had and the date:

Asthma (Asma)_____

Convulsions from any cause (Convulsions de alguns causa_____

Diabetes (Diabetes)_____

Epilepsy (Epilepicia)_____

Serious accidents (Acidentes serius)_____

Fractured/broken bones (Já quebrou ou fratutou ossos_____

Serious head injury (Problemas na cabeça)_____

If yes, give details (Se for sim, explique)_____

_____

Has your child had any operations? (Teve a sua crianca alguma operaçaõ?)

Appendix (Apendice)_____
Hernia (Hernia)_____
Tonsils; adenoids (Operaçaõ da garganta)_____
Other (Outra)_____
If yes, give details (Se for sim. Dê detalhes)_____

_____

What allergies does your child have? (Que allergies sua criança têm?) _____
_____
What foods should your child NOT eat? (Que allmentos não deve sua criança comer?)__
_____
_____

What pills, medicine, or injections give your child a reaction or sensitivity? _____
(Qual o tipo de remédio ou injeçaõ que dê reação a sua criança?)
What other medical problems does your child have _____
(Que Outro tipo de problema tem a sua criança)

Vision Testing (Teste de vista)_____ Date (Data)_____ Result (Resultado)_____
Hearing Testing (Teste de ouvido)_____ Date (Data)_____ Result (Resultado)_____
Speech Testing (Teste de fala)_____ Date (Data)_____ Result (Resultado)_____
Physical Examination (Examinaçaõ)_____ Date (Data)_____ Result (Resultado)_____
Lead poisoning Testing (Lead poisoning testing)_____ Date (Data)_____ Result (Resultado)_____