

# HEALTH INFORMATION QUESTIONNAIRE

Dear Health Care Provider: The information on this questionnaire will help us determine whether health issues may affect this child's development and learning and will help us to plan for health-related services at school. Thank you for your time and assistance. You do not need to copy your records for us. (Please provide details for any "Yes" answers.)

Child's Name: \_\_\_\_\_ DOB: \_\_\_\_\_ County: \_\_\_\_\_  
Primary Care Provider: \_\_\_\_\_ Person Completing the form: \_\_\_\_\_  
Address: \_\_\_\_\_ Date Completed: \_\_\_\_\_  
Telephone/fax: \_\_\_\_\_ Best time to reach you in the office (if needed): \_\_\_\_\_

Yes No

1.   Does this child have a neurologic problem (e.g., seizures/epilepsy, muscle weakness, hydrocephalus, cerebral palsy)? If yes, specify. \_\_\_\_\_  
\_\_\_\_\_
2.   Does this child have an orthopedic problem (e.g., scoliosis, hand or foot deformity, hip dislocation)? If yes, specify. \_\_\_\_\_  
\_\_\_\_\_
3.   Does this child have any birth defect or genetic problem (e.g., cleft palate, heart defect, Down syndrome)? \_\_\_\_\_  
\_\_\_\_\_
4.   Does this child have a chronic illness (e.g., diabetes, asthma, kidney problem)? If yes, specify. \_\_\_\_\_  
\_\_\_\_\_
5.   Are there any concerns about this child's nutrition or growth? If yes, explain. \_\_\_\_\_  
\_\_\_\_\_
6.   Is this child on a special diet? If yes, specify. \_\_\_\_\_  
\_\_\_\_\_
7.   Does this child have difficulties with feeding (e.g., choking, gagging, coughing, vomiting, slow to complete a meal)? If yes, specify. \_\_\_\_\_  
\_\_\_\_\_
8.   Does this child require special feeding techniques (e.g., adapted utensils, special positions)? If yes, specify. \_\_\_\_\_  
\_\_\_\_\_
9.   Do you have any concerns about this child's hearing? If yes, specify. \_\_\_\_\_  
\_\_\_\_\_
10.   Has this child's hearing been tested? If yes, please specify where, when and what the results were. \_\_\_\_\_  
\_\_\_\_\_
11.   Does this child have a history of chronic ear infections or tubes in ears? If yes, what is the child's current status? \_\_\_\_\_  
\_\_\_\_\_

**HEALTH INFORMATION QUESTIONNAIRE (continued)**

12.   Does this child have vision problems or wear glasses? If yes, explain. \_\_\_\_\_  
\_\_\_\_\_
13.   Does this child use assistive technology (e.g., wheelchair, prone stander, braces)? If yes, specify. \_\_\_\_\_  
\_\_\_\_\_
14.   Does this child need any health treatments daily (e.g., gastrostomy feedings, intermittent catheterization)? If yes, specify. \_\_\_\_\_  
\_\_\_\_\_
15.   Do any of these treatments need to be administered at school? If yes, specify. \_\_\_\_\_  
\_\_\_\_\_
16.   Does this child take medication every day? If yes, list the medication(s) and note any side effects of the medication of which school staff should be aware. \_\_\_\_\_  
\_\_\_\_\_
17.   Does this child need to receive medication at school? If yes, what medication, at which dosage, and at what time? \_\_\_\_\_
18.   Does this child have any allergies to medications, food or other substances? If yes, specify and describe the symptoms and any treatment that is needed if exposed to the allergen(s). \_\_\_\_\_  
\_\_\_\_\_
19.   Are any adaptation to the classroom schedule or to the environment required, or are special safety precautions necessary? If yes, describe. \_\_\_\_\_  
\_\_\_\_\_
20.   Are there any issues that you would like early intervention/early childhood special education staff to evaluate or monitor? If yes, explain. \_\_\_\_\_  
\_\_\_\_\_
21.   Do you have any other concerns about this child's health of which school staff should be aware? If yes, please describe. \_\_\_\_\_  
\_\_\_\_\_
22.   Are immunizations up-to-date? Please enclose a copy of the child's immunization record if available.

**Check here if you would like an update on this child's educational progress and a summary of the individualized family service plan (IFSP) or individualized education plan (IEP) or 504 plan.**

Please return this questionnaire to: Name: \_\_\_\_\_  
Program: \_\_\_\_\_  
Address: \_\_\_\_\_  
\_\_\_\_\_  
Telephone/fax: \_\_\_\_\_