Health Questionnaire For Kindergarten Parents

To help me get to know your child better, please read each question carefully, then check Yes or No. If you answer “yes” please describe the situation. Thank you!

1. Does your child have any food allergies? _____ No _____ Yes
   If so, please describe them:
   __________________________________________________________________________
   __________________________________________________________________________

2. Does your child have any non-food allergies? _____ No _____ Yes
   If so, please describe them:
   __________________________________________________________________________
   __________________________________________________________________________

3. Is your child on any medications? _____ No _____ Yes
   If so, please describe them:
   __________________________________________________________________________
   __________________________________________________________________________

4. Have you any specific health concerns about your child? _____ No _____ Yes
   If so, please describe them:
   __________________________________________________________________________
   __________________________________________________________________________

Child’s Name ______________________________ Birth Date ___________
5. Do you have a family doctor/health care provider?  
   No  Yes  
   Doctor’s Name: __________________________  
   If you do not have a family health care provider, do you need help getting a health care 
   provider or health insurance?  
   No  Yes  
   May the school nurse contact you about this?  
   No  Yes  

6. Does your child have any trouble sleeping at night or does your child snore, awaken at night 
   or seem very tired during the day?  
   No  Yes  
   If so, please describe:________________________________________________________________________

7. Has your child been hospitalized or had significant injuries?  
   No  Yes  
   If so, please describe:________________________________________________________________________

8. Are there recent changes or stressors in family life that you would like to share that could 
   affect your child at school?  
   No  Yes  
   If so, please describe:________________________________________________________________________

Parent Signature ________________________________ Date ______________

Danielle Wagner Plocki, BSN, RN  
School Nurse