
		h (eating and sleeping habits, weight, etc.)?
2. Yes	No	Any other specific illness or social/emotional or behavioral problems?
3. Yes	No	Any allergies (food, insects, medication, etc.)?
4. Yes	No	Any prescription medication (daily or occasionally)?
5. Yes	No	Any problems with vision, hearing, or speech (glasses, contacts, ear tubes, hearing aids)?
6. Yes	No	Any hospitalization, operation, or major illness (specify problem)?
7. Yes	No	Any significant injury or accident (specify problem)?
8. Yes	No	Would you like to discuss anything about your child's health with a school nurse?

To Parent/Guardian: Please explain any "Yes" answers from above.

I am the parent/guardian of the child named above. I give permission for the information on PARTS I and II of this form provided about my child to be reviewed and utilized only by the staff of this school and any school health personnel providing school health services in the district for the limited purpose of meeting my child's health and educational needs.

_____

Signature of Parent/Guardian **Date**

Partnership for School Readiness Recommendations for Prekindergarten and Kindergarten

To Parent/Guardian: Please obtain the services listed below in order to find any problems. Please work with your health care p 0.006hk2 276.009 Tc 0.01

1. Comprehensive Vision Examination (3-5 years of age) Date of Exam: _____ Results of Exam: _____ Health Care Provider: *(check one)* Optometrist Ophthalmologist	Please describe any corrective action for any problems detected and any accommodations required.
2. Comprehensive Dental Examination Date of Exam: _____ Results of Exam: _____ Dentist:	Please describe any corrective action for any problems detected and any accommodations required.
3. Hearing Screening Date of Exam: _____ Results of Exam: _____ Health Care Provider:	Please describe any corrective action for any problems detected and any accommodations required.