Child: _____
DOB: _____
Date: _____

Child's Health History

Ongoing Conditions	No	Yes	Condition–Currently Has or Had	No	Yes
Congenital birth defect and or syndrome			Anemia		
Constipation			Bleeding Tendencies		
Cough			Chicken Pox		
Diarrhea			Cystic Fibrosis		
Ear Infections			Other Illness:		
Hearing Impairment			Diabetes		
Hospitalization			Seizures/Epilepsy		
Rashes			High Lead Reading		
Serious Accident			Juvenile Arthritis		
Sore Throat			Scarlet Fever		
Speech Concerns?			Tuberculosis		
Stomach Pain			Whooping Cough		
Surgeries			Asthma Flare-ups (If yes, how Frequent ?)		
Urinary Infections, Trouble Urinating					
Vision Impairment					
Vomiting					
Other, Please specify					
Allergies			Items Allergic to:		
Foods					
Medications					
Insects					
Skin					
Other					

How does your child react to exposure to the allergies noted above? _____

How do you treat your child if exposed to any of the above (ex.Epipen)? _____

Is your child receiving any therapies: _____No _____Yes, please describe: _____

Medications:

Is your child presently taking any medications? _____No _____Yes
Will it need to be given while at the center? _____No _____Yes

Does your child have any choking, chewing or swallowing problems? ____No ____Yes, please describe:_____

Are you concerned about your child's health, nutrition or growth? ____No ____Yes, please describe:_____

Does your child have any particular fears?

_____

_____

Are there any behavior concerns that we should be aware of?

_____

_____

Additional Concerns:

_____

_____

_____

_____

Physician: _____
Phone: _____

Dentist: _____
Phone: _____

_____
Parent Signature