Child Health History

This form must be updated annually. Year: _____

Child's Name: _____ Birthdate _____

Please check all that apply and list any health information needed to care for your child.

Any known allergies: a No a Yes If yes, please list: _____

Medication Allergies: _____

Foods/Sensitivities: _____

Other: _____

Any chronic illnesses/medical conditions: a No a Yes Any disabilities: a No a Yes

Hearing Impairment a No a Yes
Visual Impairment a No a Yes
Developmental Delays a No a Yes
Physical Impairment a No a Yes
Emotional Problems a No a Yes
Asthma a No a Yes
Diabetes a No a Yes
Heart Problems a No a Yes
Seizures a No a Yes

Any additional health information not listed above: _____

Any routine medications your child is taking: _____
(Please see the Parent Policy Handbook for our medication policy.)

Any instructions for your child's daily care (any activities they should not engage in): _____

_____

Any instructions for child's emergency care: _____
(Please see the Parent Policy Handbook for our emergency policy.)

Tell Us About Your Child....

Favorite foods: _____ Dislikes: _____

He/She goes to sleep easiest by: _____

He/She will generally sleep _____ hours/minutes.

Favorite songs: _____ Favorite Stories: _____

As a parent, my main concerns are: _____

_____

I certify that the above health information is correct to the best of my knowledge.

_____ _____

Parent/Guardian Signature **Date**