CHILD HEALTH HISTORY/ASSESSMENT

Child's Name _____ Date of Birth: _____

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

Any known allergies/sensitivities to:

			If yes, please list:
Medications	**No**	**Yes**	_____
Foods	**No**	**Yes**	_____
Other	**No**	**Yes**	_____

Any chronic illnesses or medical conditions:*

Asthma	**No**	**Yes**
Diabetes	**No**	**Yes**
Seizures	**No**	**Yes**
Heart Problems	**No**	**Yes**

Other _____

Any disabilities:*

Hearing Impairment	**No**	**Yes**
Visual Impairment	**No**	**Yes**
Developmental Delays	**No**	**Yes**
Physical Impairment	**No**	**Yes**
Emotional Problems	**No**	**Yes**

Other _____

*If you answered yes to any of the above illness or disability questions, please be advised of our inclusion policy.

Is your child current on his/her immunizations: **Yes** **No** **Exempt**

*Please provide a copy if we do not have one on file or when immunizations are updated. Exemption letters are required, if applicable. Families with Exemptions will be asked to keep their child home, for their protection, should a known case of vaccine-preventable diseases occur in the school.

If No, Please explain: _____
_____

Any additional health information not listed above: _____
_____

Medications your child takes: _____

Any special instructions for your child's daily care: _____
_____

Name of Child's Health Insurance: _____
Policy Number: _____ Policy Holder's Name: _____

Name of Child's Medical Provider: _____
Address: _____ Phone: _____
Date of Last Physical/Well Child Check: _____

_____ _____
Parent/Guardian Signature Date