ANNUAL CHILD HEALTH HISTORY/ASSESSMENT

Child's Name _____ Date of Birth_____

Today's Dates_____ Date of Enrollment_____

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

Any known allergies/sensitivities to:	No	Yes	If yes, please list
Medications	□	□	_____
Foods	□	□	_____
Other	□	□	_____

Any Chronic illnesses or medical conditions: No Yes

Any disabilities: No Yes

Asthma	□	□	Hearing Impairment	□	□
Diabetes	□	□	Visual Impairment	□	□
Seizures	□	□	Development Delays	□	□
Heart Problems	□	□	Physical Impairment	□	□
Other_____			Emotional Problems	□	□

Any additional health information not listed above:_____

Medications your child takes:_____

Any instructions for your child's daily care:_____

_____

Date of last physical examination:_____ Date of last Dental examination:_____

Name of child's Medical Provider:_____

Address:_____ Phone:_____

Name of Child's Dentist:_____

Address:_____ Phone:_____

Instructions for child's emergency care:_____

_____

_____

Parent/Guardian Signature	Date