Child Health Assessment

(Please Write Clearly)

Name of Child ________________ Birthdate _____/ _____/ 2017

Does Your Child have any known allergies or sensitivities to the following (Check all that apply)			
	No	Yes	If **Yes** Please List
Medications			
Foods			
Other			

List any additional health information or special instructions you feel we need to be aware of:

____
____
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____
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____
____

	N	Y
Asthma		
Diabetes		
Seizures		
Heart Problems		
Hearing Impairment		
Visual Impairment		
Developmental Delays		
Physical Impairment		
Behavior or Emotional Problems		
Other:		

List any regular medications your child takes:

1.____
2.____
3.____
4.____

Name of Child's Medical Provider: _________________________________ Phone: _________________

____ ____/____/2017

Parent / Guardian Signature Date

This form must be completed for each individual child enrolled and must be reviewed annually by the parent / guardian, and any changes note:

Reviewed and/or update ____/____/20____ Parent / Guardian Signature ________________________________

Reviewed and/or update ____/____/20____ Parent / Guardian Signature ________________________________

Reviewed and/or update ____/____/20____ Parent / Guardian Signature ________________________________