Child's Health Record

Child's Name_____ Birth Date:_____

Does your child have any of the following?

Know Allergies/Sensitivities Check One □ If "Yes" please describe below:

Medications □ Yes □ No

Foods: □ Yes □ No

Other: □ Yes □ No

Has your child ever had any of the illnesses listed below?

Chicken Pox	□ Yes	□ NO	Date:_____	Measles	□ Yes	□ NO	Date:_____
Whooping Cough	□ Yes	□ NO	Date:_____	German Measles	□ Yes	□ NO	Date:_____
Mumps	□ Yes	□ NO	Date:_____	Rubella	□ Yes	□ NO	Date:_____
Rheumatic Fever	□ Yes	□ No	Date:_____	Scarlet Fever	□ Yes	□ NO	Date:_____

(If you answered "yes" to any of the above illnesses, please list the month/year that it occurred.)

Does your child frequently suffer from any of the following?

Headaches □ Yes □ NO Ear infections □ Yes □ NO

Sore Throats □ Yes □ NO Upset Stomach □ Yes □ NO

Other: (Please describe)

Does your child have any of the following?

Visual Impairment □ Yes □ No
Hearing Impairment □ Yes □ No
Physical Impairment □ Yes □ No
Emotional Problems □ Yes □ No

Please provide details here:

Has your child had any surgeries? □ Yes □ No

If you answered "yes" above, please give details with dates below:

_____

_____

Are all of your child's required immunizations current? □ Yes □ No

If you answered "No" above, please list which immunizations are needed

_____

My Child's Medical Provider is:

Name: _____

Address: _____

Phone: _____

_____

Parent/Guardian Signature Printed Name Relationship Date