License # 013423158

Child's Health Record

Child's Name: ______________________ Birth Date: _________ Sex: ________

Does your child have any of the following?

Known 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	Physical Impairment	□ Yes	□ No
Hearing 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