

Child Health Assessment



There must be a separate health assessment form for each sibling.

Name of Child		Birth Date	
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Check all that apply:

Does your child have any known allergies or sensitivities to:

	No	Yes	
Medications			If yes, please list:
Food			
Other			

Illness or Medical Conditions:

Does your child have any of the following conditions?

	No	Yes		No	Yes
Asthma			Visual Impairment		
Diabetes			Developmental Delays		
Seizures			Physical Impairment		
Heart Problems			Behavioral or Emotional Problems		
Hearing Impairment			Other:		

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

List any regular medications your child takes: _____

Name of Child's Medical Provider: _____

<i>Print Name of Parent or Guardian</i>	<i>Signature</i>	<i>Date</i>
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THIS FORM MUST BE COMPLETED FOR EACH INDIVIDUAL CHILD ENROLLED, AND MUST BE REVIEWED ANNUALLY BY THE PARENT/GUARDIAN, AND ANY CHANGES NOTED.

	Date		Parent/Guardian Name:
Reviewed and/or update:			
Reviewed and/or update:			
Reviewed and/or update:			
Reviewed and/or update:			