Child Health Assessment

There must be a separate health assessment form for each child

Child's Name _____ Date of Birth ____/____/____Age_____

Check All That Apply:

Does your child have any known allergies or sensitivities to:

	No	Yes	
Medications	☐	☐	_____
Foods	☐	☐	_____
Other	☐	☐	_____

Illnesses or Medical Conditions:

Does your child have any of the following:

	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: _____

Date of last physical exam: ____/____/____ Date of last dental exam: ____/____/____

_____ _____

Parent/Guardian Signature Date