

# Child Health Assessment

Please Write Clearly

Name of Child \_\_\_\_\_ Birthdate \_\_\_\_/\_\_\_\_/\_\_\_\_

### Check All That Apply:

Does your child have any known allergies or sensitivities to:

	No	Yes	If yes, please list:
Medications	<input type="checkbox"/>	<input type="checkbox"/>	_____
Foods	<input type="checkbox"/>	<input type="checkbox"/>	_____
Other	<input type="checkbox"/>	<input type="checkbox"/>	_____

### Illnesses or Medical Conditions:

Does your child have any of the following:

	No	Yes		No	Yes
Asthma	<input type="checkbox"/>	<input type="checkbox"/>	Visual Impairment	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	Developmental Delays	<input type="checkbox"/>	<input type="checkbox"/>
Seizures	<input type="checkbox"/>	<input type="checkbox"/>	Physical Impairment	<input type="checkbox"/>	<input type="checkbox"/>
Heart Problems	<input type="checkbox"/>	<input type="checkbox"/>	Behavioral or Emotional Problems	<input type="checkbox"/>	<input type="checkbox"/>
Hearing Impairment	<input type="checkbox"/>	<input type="checkbox"/>	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: \_\_\_\_\_

\_\_\_\_\_  
Parent / Guardian Signature \_\_\_\_\_ Date \_\_\_\_/\_\_\_\_/\_\_\_\_

Reviewed and/or update: \_\_\_\_/\_\_\_\_/\_\_\_\_ Parent/Guardian Signature: \_\_\_\_\_

Reviewed and/or update: \_\_\_\_/\_\_\_\_/\_\_\_\_ Parent/Guardian Signature: \_\_\_\_\_

Reviewed and/or update: \_\_\_\_/\_\_\_\_/\_\_\_\_ Parent/Guardian Signature: \_\_\_\_\_

This form is provided for technical assistance purposes only. Providers may use this form if they choose, but are not required to use this form.