Child Health Assessment

Name of Child_____ Birthday_____

Check all that apply:

Does your child have any known allergies or sensitivities to:

If yes please list:

Medications _____

Foods _____

Other _____

Illnesses or Medical conditions:

Does your child have any of the following:

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:_____

Parent /guardian signature_____ Date:_____

Days your child will be in the center:

Monday Tuesday Wednesday Thursday Friday

Hours in the center :_____

(we are an equal opportunity provider and employer) 2015