ANNUAL CHILD HEALTH HISTORY/ASSESSMENT

Child=s Name _____ Date of Birth _____

Today=s Date _____ Date of Enrollment _____

Please check all that apply and list any health information needed to care for your child.

Any known allergies/sensitivities to:	No	Yes	If yes, please list
Medications	☐	☐	_____
Foods	☐	☐	_____
Other	☐	☐	_____

Any chronic illnesses or medical conditions:	No	Yes
Asthma	☐	☐
Diabetes	☐	☐
Seizures	☐	☐
Heart Problems	☐	☐
Other _____		

Any disabilities:	No	Yes
Hearing Impairment	☐	☐
Visual Impairment	☐	☐
Developmental Delays	☐	☐
Physical Impairment	☐	☐
Emotional Problems	☐	☐
Other _____		

Any additional health information not listed above: _____

Medications your child takes: _____

Any instructions for your child=s daily care: _____

_____

Date of last physical examination: _____ Date of last dental examination: _____

Name of child=s Medical Provider: _____
Address: _____ Phone: _____

Name of child=s Dentist: _____
Address: _____ Phone: _____

Instructions for child=s emergency care: _____
_____
_____
_____
_____

_____ _____
(Parent/Guardian Signature) (Date)