Child Health Assessment

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

Name of Child _____ Birth Date ____/____/____

Check All That Apply:

Does your child have any known allergies or sensitivities to:

	No	Yes	If yes, please list:
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: _____

_____ ____/____/____

Parent / Guardian Signature Date

This form must be completed for each individual child enrolled, and must be reviewed annually by the parent/guardian, and any changes noted.

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.