Health Form

Child's Name: ____

(first) (middle) (last) (nickname)

Birth date: ___________________________ Phone: ______________________________

(month) (day) (year)

Parent(s)/ Guardian(s) Name(s)____

Physician's Name: _______________________________ Phone: ____________________

Dentist's Name: _________________________________ Phone: ____________________

Medical History Information

Childhood diseases: ____

Food allergies: ____

Environmental allergies: ____

Insect or animal allergies: ____

Any health problems/handicaps we should be aware of? ___________________________

____

Present Medications (drug, dose, frequency, purpose): ___________________________

____

Are there any medications which need to be kept on our premises* __________________

***If yes, we need written permission from parent and physician stating the medicine and dosage we are to dispense.

Any side effects/symptoms related to the medications which the staff need to know?

____

Dietary restrictions: ____

Activity restrictions: ____

Does child wear any prosthesis (glasses, hearing aids, limbs, false teeth, etc.) ______

If yes, please specify: ____

Is your child potty trained? __________ If not, please dress your child in pull ups, and bring extra in case of accidents.

____ ____________________

Signature of Parent/Guardian Date