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	No	Yes	Any disabilities:	No	Yes
Or medical conditions			Hearing Impairment	___	___
Asthma	___	___	Visual Impairment	___	___
Diabetes	___	___	Developmental Delays	___	___
Seizures	___	___	Physical Impairment	___	___
Heart Problems	___	___	Emotional Problems	___	___
Other	____________________		Other	____________________	

Any Additional health information not listed above:
____
____

Medications your child takes: ____

Any instructions for your child's daily care:____

____ ____________________________

(Parent signature) (Date)