HEALTH DATA
SCHOOL YEAR 20__-20__

CHILD'S NAME_____BIRTH DATE_____M___F___

Where does your child go for health care?

Name of clinic/hospital_____

Family doctor_____

Address_____

When was the last time your child was seen by a clinic or doctor?_____

What was the visit for? (Illness, routine check up, etc.)_____

What medications, if any, does your child take regularly? (Vitamins, pills, asthma, etc)

_____

Does your child have any special difficulties or problems his/her teacher should be aware of? (Coordination, hearing, vision, hyperactivity, frequent colds, emotional problems, frequent illness, relationship with other children or adults, etc.)

Please describe_____

Has your child ever been in the hospital? Yes____No____

If yes, when:____Please describe what happened_____

_____

A REGISTERED NURSE IS AVAILABLE AT THE PRESCHOOL PERIODICALLY TO EXAMINE THE CHILD'S VISION, HEARING AND OVERALL HEALTH STATUS. PLEASE SIGN IF YOU GIVE PERMISSION FOR SUCH HEALTH EXAMINATIONS.

_____ _____

Signature Parent or Legal Guardian Date