

Child Health Assessment

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	<input type="checkbox"/>	<input type="checkbox"/>	_____
Foods	<input type="checkbox"/>	<input type="checkbox"/>	_____
Other	<input type="checkbox"/>	<input type="checkbox"/>	_____

Illnesses or Medical Conditions:

Does your child have any of the following conditions?

	No	Yes		No	Yes
Asthma	<input type="checkbox"/>	<input type="checkbox"/>	Visual Impairment	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	Developmental Delays	<input type="checkbox"/>	<input type="checkbox"/>
Seizures	<input type="checkbox"/>	<input type="checkbox"/>	Physical Impairment	<input type="checkbox"/>	<input type="checkbox"/>
Heart Problems	<input type="checkbox"/>	<input type="checkbox"/>	Behavioral or Emotional Problems	<input type="checkbox"/>	<input type="checkbox"/>
Hearing Impairment	<input type="checkbox"/>	<input type="checkbox"/>	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 Name _____ 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 Name: _____
Reviewed and/or update: ____/____/____	_____
Reviewed and/or update: ____/____/____	_____

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.