# Child's Health Record

Child's Name: _____ Birth Date: _____ Sex: _____

Does your child have any of the following?

| Known Allergies / Sensitivities | Check One | If "Yes", please describe below: |
|---|---|---|
| Medications: | □ Yes □ No | |
| Foods: | □ Yes □ No | |
| Other: | □ Yes □ No | |

Has your child ever had any of the illnesses listed below?

| | | | | | |
|---|---|---|---|---|---|
| Chicken Pox | □ Yes □ No | Date: ____ | Measles | □ Yes □ No | Date: ____ |
| Whooping Cough | □ Yes □ No | Date: ____ | German Measles | □ Yes □ No | Date: ____ |
| Mumps | □ Yes □ No | Date: ____ | Rubella | □ Yes □ No | Date: ____ |
| Rheumatic Fever | □ Yes □ No | Date: ____ | Scarlet Fever | □ Yes □ No | Date: ____ |

(If you answered "Yes" to any of the above illnesses, please list the month / year that it occurred)

Does your child frequently suffer from any of the following?

| | | | |
|---|---|---|---|
| Headaches | □ Yes □ No | Ear Infections | □ Yes □ No |
| Sore Throats | □ Yes □ No | Upset Stomach | □ Yes □ No |

Other (please describe):

Does your child have any of the following?

| | | | |
|---|---|---|---|
| Visual Impairment | □ Yes □ No | Physical Impairment | □ Yes □ No |
| Hearing Impairment | □ Yes □ No | Emotional Problems | □ Yes □ No |

Please provide details here:

Has your child had any surgeries? ☐ Yes ☐ No

If you answered "Yes" above, please give details with dates below:

_____

Are all of your child's required immunizations current? ☐ Yes ☐ No

If you answered "No" above, please list which immunizations are needed

_____

My child's Medical Provider is:

Name: _____

Address: _____

Phone: _____

_____

Parent / Guardian Signature Printed Name Relationship Date