HEALTH FORM FOR LITTLE ONES' PRESCHOOL

NAME OF CHILD: ________________________________ GENDER: _____

BIRTHDAY: _______________ PARENTS' NAMES: ______________________
(Month, Day, Year born)

ADDRESS: ____
(Street) (City) (Zip Code)

PHONE: ______________________________ CELL: __________________

MEDICAL HISTORY *(To be filled out by parent)*

Has your child ever been seriously ill? (Briefly explain, use back if needed)

Does your child have allergies? List food or other things he/she is allergic to. How does he/she react?

Does your child hear well? Yes _________ No ________ If "no", describe.

Does your child have any visual challenges? Please explain.

What childhood diseases has your child had?

PHYSICAL CONDITION (To be filled out by physician and signed)

What is the child's general physical condition?

Are all immunizations up to date? (Attach immunization record to this form)

Is there any special situation of which the school should be aware?

DATE: _________________ SIGNED: ______________________________
(Physician)