
# HEALTH FORM FOR LITTLE ONES' PRESCHOOL

NAME OF CHILD: _____ GENDER: _____

BIRTHDAY: _____ PARENTS' NAMES: _____

ADDRESS: _____

PHONE: _____ _____

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

Has your child ever been seriously ill? Yes _____ No _____ (Briefly explain, use back if needed)

Does your child have allergies? Yes _____ No _____ 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 on back.

Does your child have any visual challenges? Yes _____ No _____ Please explain.

What childhood diseases has your child had?

## PHYSICAL CONDITIONS *(To be filled out by physician and **Signed.**)*

What is the child's general physical condition?

Are all immunizations up to date? **(Please attach immunization record to this form.)**

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

**SIGNED:** _____ **DATE:** _____