HEALTH HISTORY

Child's name ___________________ Sex _______ DOB___________

Medical History (Please check all that apply)

_____ Epilepsy _____Pneumonia _____Apnea

_____Heart Disorder _____Whooping Cough _____Diphtheria

_____Seizures _____Tuberculosis _____Hepatitis B

_____HIB _____Measles _____Mumps

_____Rubella _____Asthma _____Chicken Pox

Other ____

Allergies

Medication _____________________________

Reaction _____________________Emergency plan__________________

Food(s) _________________________________

Reaction _____________________Emergency plan__________________

Insects bites _______________________________

Reaction _____________________Emergency plan__________________

Comments and concerns we need to know about your child: __________

____.

Parent signature __________________________Date ___