CHILD'S HEALTH FORM

Little Stars Preschool & Development Center

Child's Name _____ Nickname: _____

Birth Date: _____ Child's Physician _____

Physician's Phone Number _____

Is your child currently under the care of a physician? Yes No

Please describe your child's current physical health Good Fair Poor

Medical Conditions: (please circle)

Has your child had any of the following?

Heart Murmur	Bronchitis	Hearing	Hyperactive	Surgeries	Hepatitis
Convulsions / Epilepsy	Aids/HIV	Heart Disease	Asthma	Hospitalization	Impairment
Polio	Sinus Problems	Diabetes	Cancer	Kidney/Liver Problems	

Has your child had any serious medical conditions not listed above? Yes No

If yes, please explain: _____

Does your child have any Handicaps/Disabilities? Yes No

If yes, please explain: _____

Illnesses: (please circle)

Does your child have any problems with any of these? Yes No

Lice	Convulsions	Ringworm	Diarrhea	Skin Rash	Soiling
Frequent Colds	Stomach Upsets	Frequent Ear Infections		Worms	Fainting Spells
Urinary Problem	Frequent Sore Throats	Constipation			

Diseases: (please circle)

Has your child had any of these? Yes No

Chicken Pox	Measles	German measles	Mumps	Scarlet Fever	Tuberculosis
Cytomegalovirus	Fifth Disease	Whooping Cough	Meningitis	Pinkeye	Strep Throat
Rheumatic/Scarlet Fever	Ringworm	Pinworms	Hand, Foot & Mouth Disease		Impetigo

Is your child taking any medicine? Yes No

If yes, what is the name of the medicine? _____

How often does your child need to take this medicine? _____

Will you child need to take the medication while in the center? Yes No

Has your child had any allergic reactions to medicine, DTP, or other shots or insects? Yes No

Please list all drugs your child is allergic to _____

Food allergies: _____

Medicine allergies: _____

Other Allergies: Yes No

If yes, please list them: _____

Has your child had more than two ear infections in a year?	Yes No
Has your child had tonsillitis?	Yes No
Has your child ever had reaction to the TB skin test?	Yes No
Has your child ever been with anyone having TB?	Yes No
Is your child a hemophiliac (free bleeder)?	Yes No
Does he/she have seizures, fits or shaking spells?	Yes No
Does your child have speech or hearing problems?	Yes No
Does your child have trouble with his eyes or seeing?	Yes No
Is your child able to play as hard as other children?	Yes No
Does your child have tubes in his/her ears?	Yes No
Does your child get along well with other children?	Yes No
Is he/she usually happy?	Yes No
Does your child have herpes?	Yes No
Does your child have any special problems not indicated above?	Yes No

If yes, please explain:_____

When did your child last see a doctor: Month _____Year? _____

Has your child ever been in the hospital overnight? Yes No

If yes, why? _____

Any Operations? Yes No

If yes, please explain ? _____

I understand that the information I have given is correct to the best of my knowledge, that it will be held in the strictest of confidence.

Parent Signature: _____