Child's Name: ______________________ Nick Name : ___________

Birth Date: ________________

Child's Physician : ____

Telphone 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 you child had any of these? ☐ Yes ☐ No

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

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 my home? ☐ 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.