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 ___