Child Medical History

NAME _____ DATE _____

Does your child have chronic health conditions or problems? ☐ Yes ☐ No

If so, please explain: _____

_____

Does your child take any medication(s)? ☐ Yes ☐ No

If yes, please list name of medication(s) and reason for taking: _____

_____

Does your child have allergies? ☐ Yes ☐ No

If so, list allergens and typical reaction to them: _____

_____

Please list any other health condition the preschool staff should be aware of (this will remain confidential):

_____

_____

Physician's Information	**Dentist's Information**
Name	Name
Address	Address
City	City
State Zip Code Phone Number	State Zip Code Phone Number

_____ _____

Parent/Guardian Signature Date