Little Blue Dolphins Daycare & Preschool

Lic: 013422752

Child's Health Record

(Child's Name) (D.O.B.) (Sex)

Does your child have any of the following?

Known Allergies/ Sensitivities. Check One

Medications:	**Yes** ☐	**No** ☐
Foods:	**Yes** ☐	**No** ☐
Other:	**Yes** ☐	**No** ☐

(If you answered "Yes" to any of the above, please list them)

Has your child ever had any of the illnesses listed below?

Chicken Pox	**Yes** ☐	**No** ☐	**Measles**	**Yes** ☐	**No** ☐
Wooping Cough	**Yes** ☐	**No** ☐	**German Measles**	**Yes** ☐	**No** ☐
Mumps	**Yes** ☐	**No** ☐	**Rubella**	**Yes** ☐	**No** ☐
Rheumatic Fever	**Yes** ☐	**No** ☐	**Scarlet Fever**	**Yes** ☐	**No** ☐

(If you answered "Yes" to any of the above illnesses, please list the month / year that it occured)

Does your child frequently suffer from any of the following?

Headaches	**Yes** ☐	**No** ☐	**Ear Infections**	**Yes** ☐	**No** ☐
Sore Throats	**Yes** ☐	**No** ☐	**Upset Stomach**	**Yes** ☐	**No** ☐

(If you answered "Yes" to any of the above symptoms, please list the month / year that it occured)

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Does your child have any of the following?

Visual Impairment	**Yes** ☐	**No** ☐	**Physical Impairment**	**Yes** ☐	**No** ☐
Hearing Impairment	**Yes** ☐	**No** ☐	**Emotional Problems**	**Yes** ☐	**No** ☐

(If you answered "Yes" to any of the above, please list them)

Has your child had any surgeries? **Yes** ☐ **No** ☐

(If you answered "Yes" to any of the above, please list them)

Are all of your child's required immunization current? **Yes** ☐ **No** ☐

(If you answered "No" above, please list which immunizations are needed below)

My child's Medical provider is:

Name:

Address:

Phones:

INS #

EMAIL

Date

parent or guardian