CHILD'S PREADMISSION HEALTH HISTORY – PARENT'S REPORT

CHILD'S NAME:	☐ MALE ☐ FEMALE	BIRTHDATE:
Father's Name: Does father live in home with child? ☐ Yes ☐ No	Mother's Name: Does mother live in home with child? ☐ Yes ☐ No	
Is/has child been under regular supervision of a physician? ☐ Yes ☐ No		Date of last physical examination:
Name of the physician:		Physician's phone:
Name of the dentist:		Dentist's phone:

PAST ILLNESSES – Check illnesses that your child has had and specify their approximate dates:

Illness Date	Illness Date	Illness Date
☐ Chicken Pox	☐ Diabetes	☐ Poliomyelitis
☐ Asthma	☐ Epilepsy	☐ Ten-Day Measles (Rubeola)
☐ Rheumatic Fever	☐ Whooping cough	☐ Three-Day Measles (Rubella)
☐ Hay Fever	☐ Mumps	☐ Other
Specify any other serious or severe illnesses or accidents:		

Does child use any special device(s)? ☐ Yes ☐ No If yes what kind?	Does child take prescribed medication? ☐ Yes ☐ No If yes what kind & any side effects?
Please Note: If you answered Yes to the above questions, you need to fill out "Parent Permission Consent for Medication Administration" in order for your child to be able to use or take the device(s) or medication at school. Also, you need to provide the device / medication to be kept with the school's emergency supplies (earthquake bag).	

Does your child have a special medical condition? ☐ Yes ☐ No If yes please explain:
Is your child currently on any medication? ☐ Yes ☐ No If yes please explain:
Does your child have any allergies: ☐ Yes ☐ No If yes please explain:
Does your child have any dietary limitations? ☐ Yes ☐ No If yes please explain:
Has your child been diagnosed with any learning or physical disability? ☐ Yes ☐ No If yes please explain:
Is there anything else that we should know about your child? ☐ Yes ☐ No If yes please explain:

Parent's Signature:…….. Date:……..