CHANGE IN MEDICAL HISTORY

Child Name:

Health Information

MEDICATION

Does your child take medication regularly? ▢ Yes ▢ No ▢ Occasionally

If yes, what and for what reason? _____

ALLERGIES

Is your child allergic to any foods? ▢ Yes ▢ No (If yes, A note from doctor is required for all food allergies)

If yes, what food(s)? _____

Does your child have any other allergies (i.e. bee stings, dust, others)? ▢ Yes ▢ No

If yes, list all allergies? _____

If yes, list all medications? _____

HEALTH HISTORY

Has your child had any of the following?:

▢ Chicken Pox ▢ Scarlet Fever ▢ Mumps ▢ Measles ▢ Hepatitis ▢ Seizures ▢ TB

Does your child have frequent colds or ear infection? _____

Does your child run high fevers? _____

Has your child ever had a hearing test? _____

Has your child ever had a vision test? _____

Please give an overall statement about your child's past and present health:

_____

_____

_____