

Medical Information



Please complete, sign and date this form and mail it to your center director:

Child's name _____ Birth date _____

Allergies _____

Date (month/year) of last doctor's visit _____ Please specify reason _____

Please check all boxes that apply:

Birth

Term Premature Number of weeks premature _____

Child's development

Normal Delayed. Please specify _____

Medical conditions your child has or has had

Asthma

Uses inhaler. Frequency _____

Receives breathing treatments. Frequency _____

Behavioral issues

ADD ADHD Others. Please specify _____

Current medications _____

Methods used to improve behavior _____

Bronchitis. Current medication(s) _____

Diabetes. Current medication(s) _____

Eating/feeding issues

.. Choking .. Cholic .. Frequent spitting up .. Poor appetite
.. Failure to gain weight .. Other _____
Current medication(s) _____
.. GI issues
.. Frequent diarrhea .. Vomiting Medication(s) _____
.. Repeated infections. Please specify _____
Medication(s) _____
.. Seizure disorder Medication(s) _____
.. Skin conditions
.. Excema .. Dermatitis .. Severe diaper rash .. Ring worm .. Lice
.. Rash. Please specify _____
.. Other conditions. Please specify _____

In order to better ensure that my child receives appropriate care, I have answered the above questions as accurately as possible.

Parent's Signature _____ Date _____