TODAY'S KIDS
childcare & learning center
Today's Kids are Tomorrow's Future

Medical & Health Information Form

Child's Name:

_____

Child's Date of Birth: _____/____/_____
Pediatrician's Name:

_____
Phone Number: _____

Please check all illnesses that apply:

3 Day Measles ___ Date: _____
10 Day Measles ____ Date: _____
Chicken Pox ___ Date: _____
Whooping Cough ____ Date: _____
Rheumatic Fever ___ Date: _____
Poliomyelitis ___ Date: _____

Does your child suffer from any of the following?

Hay Fever ____ Epilepsy____
Asthma ____ Diabetes ____
Frequent Colds ____ Allergies____
Seizures____
Other: _____

Please list ANY allergies and your child's reaction to the allergen.

_____
_____
_____

Does your child any current medical problems? YES NO
If YES, please explain:_____
_____
_____

Is your child taking regular daily medication?
YES NO
If YES, please list the medications being taken:

_____
_____

Does your child use ANY special medical devices?
YES NO
If yes, please explain:

_____
_____
_____

Does your child have ANY physical or mental handicaps?
YES NO
If yes, please explain:

_____
_____

DAILY ROUTINES

Does your child normally take a nap? YES NO
Does your child normally eat well? YES NO
Is your child potty-trained? YES NO
Has your child attended daycare before? YES NO
Does your child play well with others? YES NO
Does your child have tantrums? YES NO
Does your child take a pacifier? YES NO
Does your child have a blankie/object? YES NO

Please list any other information you think will be helpful to us in providing quality care to your child?

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____