Medical History Form

Child's Physician Name:_____
Physicians Phone Number:_____
Hospital Preference (for emergencies)_____

1. Has your physician approved the use of any non-prescription medications for your child such as acetaminophen, or ointments that can be given by the child care provider? No Yes, as follows: _____
_____

2. Does your child have any of the following conditions? Please answer yes or no.
Allergies (seasonal) Y/N If yes please explain:
_____
_____

Allergies (food) Y/N If yes please explain:
_____
_____

Frequent sore throats/colds Ear Aches Y/N
If yes, Please
explain_____
_____

Asthma Y/N If yes please explain:
_____
_____

Epilepsy/Seizures Other Y/N
If yes please explain:
_____
_____

3. Have there been changes at home that might affect your child in care? Y/N
If Yes, Please Explain:_____
_____

4. Please provide additional information or special instructions that will help the person caring for your child:_____
_____
_____