

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: _____

Text

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: _____
