|  |  |  |
| --- | --- | --- |
| **Childs Name *(First, Middle, Last)*** | **Sex:**  F ❑ M ❑ | **Birthdate:** |
| **Child’s Doctor: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Last Visit: \_\_\_\_\_\_\_\_\_\_\_**  **Child’s Dentist: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Last Visit: \_\_\_\_\_\_\_\_\_\_\_** | | **Health Insurance Medical & Dental:**  *(check one)*  ❑ **Medicaid** ❑ **Private**  ❑  **Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** |

**Please circle if your child has any of the following:**

Allergy\*

Allergy to food\*

Anemia

Asthma\*

Bowel/Bladder problems

Diabetes\*

Frequent earaches/Infections

Frequent nose bleeds

Hearing problems/Wears hearing aid

Heart condition\*

High lead level

Lactose Intolerance

Reactive Airway Disease (R.A.D)\*

Second hand smoke exposure

Seizure disorders\*

Serious Illness/Injury

Surgery/Hospitalizations

Vision Problems/Wears Glasses

Wheezing\*

Other Serious Disorders

Please explain anything circled above:

Do you have concerns about your child’s overall health or development?

|  |  |  |  |
| --- | --- | --- | --- |
| **YES** | **NO** | **MEDICATION** | **COMMENTS/EXPLAIN** |
|  |  | Does your child take medication? |  |
|  |  | Will your child need to take medication while in our care? (Yes indicates a need for a ***Medication Form***) |  |
|  |  | Does your child use any form of emergency medication?  Ex. Epi-pen, inhaler… |  |

|  |  |  |  |
| --- | --- | --- | --- |
| **YES** | **NO** | **ORAL HEALTH ASSESSMENT** | **COMMENTS/EXPLAIN** |
|  |  | Has your child seen a dentist? |  |
|  |  | Has your child ever had a cavity? |  |
|  |  | Does your child complain of mouth pain? |  |
|  |  | Do you help your child brush his/her teeth? |  |

|  |  |  |
| --- | --- | --- |
| \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Parent/Guardian Signature | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Date | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  2nd Year Review Date |

**FOR OFFICE USE ONLY:**

Additional documents required before a child can start: ❑ Physical Records ❑ Physician Records

❑ Individual Health Plan ❑ Medication Form ❑ Dietary Restriction Request ❑ Allergy Restriction Request

❑ Allergy Action Plan ❑ Asthma Action Plan ❑ Seizure Plan ❑ Toileting ISP ❑ None

Rev: 3/24 MG