



CHILD'S PREAMMISSION HEALTH HISTORY – PARENT/GUARDIAN'S REPORT

Child's Name	Gender	Date of Birth
Father/Guardian's Name	Age	Does the father/guardian live in home with child?
Mother/Guardian's Name	Age	Does the mother/guardian live in home with child?
Has the child been under regular supervision of a physician?		Date of last examination

DEVELOPMENTAL HISTORY

Walked at: _____ months	Began talking at: _____ months	Toilet training started at: _____ months
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ILLNESSES – Check those illnesses that the child has had and give approximate dates:

	Dates		Dates		Dates
<input type="checkbox"/> Chicken pox <input type="checkbox"/> Asthma <input type="checkbox"/> Rheumatic fever <input type="checkbox"/> Hay fever		<input type="checkbox"/> Diabetes <input type="checkbox"/> Epilepsy (Seizure Disorder) <input type="checkbox"/> Whooping cough (Pertussis) <input type="checkbox"/> Mumps		<input type="checkbox"/> Poliomyelitis <input type="checkbox"/> Ten-day measles (Rubeola) <input type="checkbox"/> Three-day measles (Rubella)	

Other serious or severe illnesses or accidents?

Does child have frequent colds?	How many in last year?	List any allergies staff should be aware of:
Has a bee ever stung your child? Yes _____ No _____	Did your child have any reactions to the bee sting? (Explain)	

DAILY ROUTINES

What time does child get up?	What time does child go to bed?	Does child sleep well?
Any food dislikes?	Any eating problems?	

Parent/Guardian's evaluation of child's health:

Parent/Guardian's evaluation of child's personality:

How does the child get along with parents, brothers, sisters, and other children?

Has the child had group play experiences?

Does the child have any special problems or fears? (Explain)

What is the plan for care when the child is ill?

Last Child Care Program attended:

Signature of Parent/Guardian	Date
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