Child's Name: _____

Health Care and History

Child's Physician: _____ Phone: _____

Please circle YES, NO, or N/A for each of the following:

ALLERGIES- **YES NO N/A**

_____ Food- list food(s): _____

_____ Insect Stink- list insect(s): _____

_____ Other- list: _____

Currently prescribed medications and treatments:

_____ Oral anthistamine (Benadryl, etc.) ____ Epi-pen ____Other _____

ASTHMA- **YES NO N/A**

List Triggers _____

Does your child experience asthma symptoms with exercise? _____

SEIZURE DISORDER- **YES NO N/A**

Describe: _____

SPECIAL DIET required- YES NO N/A

Describe: _____

OTHER HEALTH CONDITIONS-

Describe: _____

SPEECH AND/OR LANGUAGE DELAY

Is your child currently receiving speech and/or language therapy services?

YES or **NO**

Has your child received speech and/or language therapy services?

YES or **NO**

Please describe the areas of concern: _____

_____

_____

OTHER:

Any other pertinent information we should know regarding your child's medical needs or that may require special attention: _____

_____