

CHILD'S PREADMISSION HEALTH HISTORY-PARENTS REPORT

School Year: 2010-2011

Child's Name (Last)	(Middle)	(First)	Sex:	Birth date:
Father's/Guardian's/Domestic Partner's Name			Does this person live in the home with the child? Yes No	
Mother's/Guardian's/Domestic Partner's Name			Does this person live in the home with the child? Yes No	
Past Illnesses - Check illnesses that child has had and specify approximate date of illnesses:				
<input type="checkbox"/> Chicken Pox <input type="checkbox"/> Asthma <input type="checkbox"/> Rheumatic Fever <input type="checkbox"/> Hay Fever	Dates: <input type="checkbox"/> Diabetes <input type="checkbox"/> Epilepsy <input type="checkbox"/> Whooping Cough <input type="checkbox"/> Mumps	Dates: <input type="checkbox"/> Poliomyelitis <input type="checkbox"/> Ten-Day Measles (Rubeola) <input type="checkbox"/> Three-Day Measles (Rubella)		
Specify any other serious illness or accidents:				
Does your child have frequent colds? ___Yes ___No			How many colds in the last year? _____	
DEVELOPMENTAL HISTORY:				
Walked at: _____ months Talked at: _____ months Toilet Training started at: _____ months				
DAILY ROUTINES:				
What time does your child get up? _____	What time does your child go to bed? _____	Does your child sleep well? _____		
Does your child sleep during the day? _____ When? _____ For how long? _____				
Diet Pattern:				
What foods does your child like?	Dislikes?			
Is child presently under a doctor's care? _____yes ___no	If yes, please describe:			
Does your child use any special devices? _____yes ___no	If yes, please describe:			
ALLERGY INFORMATION:				
Does your child have any mild allergies? _____				
Does your child have severe allergies? _____ If so, what are they? _____				
Does your child use an EPI-PEN? ___Yes ___No				
Does your child have any special needs/fears/problems? (Explain)				

Signature of Parent/Guardian/Domestic Partner or Authorized Representative

Date

(OVER)