Preschool Health History Form

Child's Information

Full Name

Date of Birth

Gender

Select

Home Address

Parent/Guardian Information

Parent/Guardian Name

Phone Number

Email Address

Medical History

Child’s Primary Physician

Physician Phone Number

Does your child have any of the following? (Check all that apply)

Allergies

Asthma

Seizures

Diabetes

☐

Other

If any checked, please provide details:

Immunization & Medication

Are your child's immunizations up to date?

Select

List any medications your child currently takes:

Emergency Contacts

Contact Name

Phone Number

Contact Name

Phone Number

Additional Information

Other relevant health information or concerns: