

Community Christian Academy

Preschool & Childcare

CHILD HEALTH INFORMATION

Child's Name (Last, First):		
<input type="checkbox"/> Male <input type="checkbox"/> Female	Date / /	DOB / /
Please check any of the following symptoms that have been noted: <input type="checkbox"/> Frequent sore throats <input type="checkbox"/> Frequent headaches <input type="checkbox"/> Frequent stomachaches <input type="checkbox"/> Convulsions <input type="checkbox"/> Shortness of breath <input type="checkbox"/> Poor appetite <input type="checkbox"/> Pain in legs or joints <input type="checkbox"/> Tires easily <input type="checkbox"/> Frequent nosebleeds <input type="checkbox"/> Frequent urination <input type="checkbox"/> Frequent earaches <input type="checkbox"/> Frequent sties <input type="checkbox"/> Fainting spells	DISEASES: <input type="checkbox"/> 4 or more colds a year <input type="checkbox"/> Measles <input type="checkbox"/> Diabetes <input type="checkbox"/> Heart Disease <input type="checkbox"/> German Measles <input type="checkbox"/> Pneumonia <input type="checkbox"/> Undulant Fever <input type="checkbox"/> Asthma, Hay Fever <input type="checkbox"/> Poliomyelitis <input type="checkbox"/> Ear Infections <input type="checkbox"/> Mumps <input type="checkbox"/> Hernia rupture <input type="checkbox"/> Tonsillitis <input type="checkbox"/> Chicken Pox <input type="checkbox"/> Eczema <input type="checkbox"/> Tuberculosis <input type="checkbox"/> Other _____	List any operations, injuries, deformities: List any other remarks regarding your child's health, mental, or emotional development you would like to call to our attention:
ALLERGIES: <input type="checkbox"/> Bee <input type="checkbox"/> Nut <input type="checkbox"/> Wheat <input type="checkbox"/> Dairy <input type="checkbox"/> Other: _____ REACTION: _____	Has your child ever been exposed to Tuberculosis? <input type="checkbox"/> Yes <input type="checkbox"/> No	
PREVENTIVE HEALTH SCREENINGS		
Type Screening	Date	Note if Abnormal
Hearing		
Vision		
Dental		
Developmental		
Other		
<input type="checkbox"/> The information above is accurate.		Date / /
Parent Signature:		