

School-Age Child Health Form/Parent Statement of Health

Parent/Guardian complete this page

Child name: _____

Please use an X in the box to statements that apply to your child.

Date of child's last physical exam: _____

Date of last dental appointment: _____

Growth

I am concerned about child's growth.

Appetite

I am concerned about child's eating habits.

Rest

My child needs to rest after school.

Illness/Surgery/Injury

My child had a serious illness, surgery, or injury.

Please describe: _____

Physical Activity - My child

Must restrict physical activity or needs special equipment to be active. Please describe: _____

Play with friends - My child

- Plays well in groups with other children.
- Will play only with one or two other children.
- Prefers to play alone.
- Fights with other children.
- I am concerned about my child's play activity with other children.

School and Learning - My child

- Is doing well at school.
- Is having difficulty in some classes.
- Does not want to go to school.
- Frequently misses or is late for school.
- I am concerned about how my child is doing in school. Please describe: _____

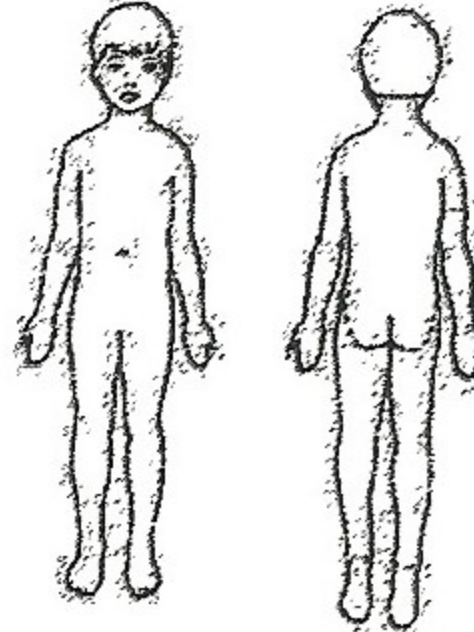
Allergy - My child has allergies (Medicine, food, dust, mold, pollen, insects, animals, etc.). List allergies: _____

Special Needs Care Plan - My child has a special needs care plan (IEP, Asthma Action Plan, Food Allergy Action Plan, etc.). Please discuss with your health care provider.

Body Health - My child has problems with

Skin, hair, fingernails or toenails.

Describe skin marks, birthmarks, or scars. Show us where these skin marks are located using the drawing below.



- Eyes/vision, glasses or contact lenses
- Ears/hearing, hearing assistive aides or device, earache, tubes in ears
- Nose problems, nosebleeds
- Mouth, teeth, gums, tongue, sores in mouth or on lips, breaths through mouth
- Frequent sore throats or tonsillitis
- Breathing problems, asthma, cough
- Heart problems or heart murmur
- Stomach aches or upset stomach
- Trouble using toilet or wetting accidents
- Hard stools, constipation, diarrhea, watery stools
- Bones, muscles, movement, pain when moving
- Mobility, child uses assistive equipment
- Nervous system, headaches, seizures, or nervous habits (like twitches or tics)
- Females - difficult monthly periods
- Other special needs. Please describe: _____

Medication¹ - My child takes medication.

Medication Name	Time Given	Reason for giving medication

Child has Epipen, inhaler, or other emergency medication.

Yes No

Parent Signature
(required)

Date: _____

¹ Parents: Please review the child care program's policies about the use of medication at child care.