

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.

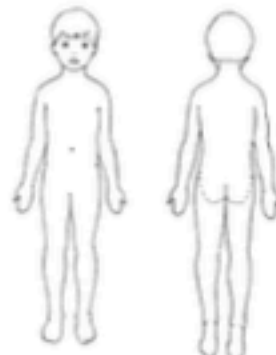
Parent Signature:
(required)

Date:

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

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