

Health Record

Name of Child (print or type) _____ Date of Birth _____

Name of Parents or Guardian _____

1. **Allergies** (List all allergies affecting the child and any special precautions or treatments indicated for these allergies.) _____

2. **Medications or Food Supplements** (List all medications or food supplements currently being administered to the child.) _____

3. **Dietary Restrictions** (List all modified dietary restrictions affecting the child.) _____

4. **Chronic Physical Problems** (List all chronic physical problems affecting this child.) _____

5. **History of Hospitalizations** (List dates or all hospitalizations of the child.) _____

6. **Diseases** (List all diseases that the child has had.) _____

7. **Medical Treatment** – Should the need arise to treat a cut or scrape on my child, I permit the use of Neosporin _____ Yes _____ No

Parent Signature: _____

TODAY'S DATE: _____