

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: _____