PRECIOUS FRUITS CHILD CARE
HEALTH HISTORY

____ M/F ________________
Child's Last Name First Middle Nickname Sex Date

Birth Date ______________ Birthplace ___________________ SS# ____________________

____ ________________
Address City Zip Home Phone

Mother's Name _____________________________ Address _____________________
Mother's Home Phone ________________ Work _______________ Cell _____________

Father's Name _____________________________ Address _____________________
Father's Home Phone _________________ Work _______________ Cell _____________

Sibling's names and ages:
____

Child's favorite foods or dislikes:
____

Who else will be authorized to pick up your child? (Parent must call ahead of time)

________________ Relationship ____________ Phone (h) ____________ (w) ____________
________________ Relationship ____________ Phone (h) ____________ (w) ____________
________________ Relationship ____________ Phone (h) ____________ (w) ____________

Has your child ever been hospitalized overnight? _________ When? ____________________
Is your child on any medication? ______ Names of Medication: ______________________
If your child needs to take medication at care center it must be in a label bottle with child's name.

Does your child have any allergies? _____ If so, please list ___________________________

Name of child's Doctor ___________________________ Phone _______________________

________________________________ __________________
Parent/Guardian Signature Date

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CHILD'S ILLNESS (past or present) Yes No

Chickenpox ______________________________
Rubeola (10 Day measles) _________________
Rubella (3 day measles) ___________________
Asthma _________________________________
Drug/Food Allergy _________________________
Seizures ________________________________
Unconscious _____________________________
Eczema/Hives ____________________________
Positive TB skin test _______________________

Hearing Loss ___________________________
Speech Problems ________________________
Eye Problems ___________________________
High Blood Pressure ______________________
Heart Problems/murmur ___________________
Kidney Problems ________________________
Diabetes _______________________________
Blood Disease (HIV, etc.) ________________

Any other medical concerns____

IMMUNIZATION HISTORY (Medical record/book must be presented)

PT/DT 1st ________
2nd ________
3rd ________
4th ________
5th ________

HIB __________
____

POLIO 1st _________
2nd _________
3rd _________
4th _________
5th _________

MMR _________ 2nd _______
Rubeola __________
Rubella __________
Mumps ___________

Hepatitis B 1st _______________ 2nd ______________ 3rd _________________
Mantoux (PPD) TB skin test _________________

____
Parent/Guardian Signature

____
Date