CHILD HEALTH ASSESSMENT

Section A: To be Completed by Parent/Guardian

Child's Name: ______________________________ Birth Date: __________________________
Parent/Guardian: ___________________________ **Preferred Phone**: ______________________

Has your child been tested or received medical or professional services for any of the following?

Developmental Disability ___ yes ___no
Speech Therapy ___yes ___no
Behavioral Services ___yes ___ no
Occupational Therapy ___yes ___no
Other Health Impairment (i.e., ADHD) ___ yes ___no
Seizure Disorder ___yes ___no
Physical Therapy ___ yes ___no
Other, please list: ____

All children who are receiving services by the Intermediate Unit are required to have a meeting with the teacher and director prior to the start of preschool. Please call so we can arrange a date and time. This will provide our staff the opportunity to work with the family for the educational benefit of the child.

Does your child take any medications regularly? Yes No If Yes, Name of meds & dosage:
____

Does your child have any allergies? Yes No If yes, please list:
____

Does your child have seasonal allergies? Yes No If yes, please describe typical symptoms:
____

Does your child have any food allergies? Yes No If yes, please list:
____

Is there any other information regarding your child that may be helpful to the teacher in meeting your child's needs? Yes No If yes, please describe:
____
____

***For all allergies, please send the preschool documentation from your child's pediatrician.**

Please be aware that the preschool does not have nurse or other medical personnel on site.

***** (If your child has a life, threatening allergy, request medical allergy forms for student files)***

Parent/Legal Custodian Signature ____________________________________ Date ______________

Parent/Legal Custodian Signature ____________________________________ Date ______________

Signature implies accuracy and agreement of the above information.