CHILD HEALTH ASSESSMENT

Section A: Completed by Parent/Guardian **Child's class:**

Child's Name: ______________________________ Birth Date: ___________________________
Parent/Guardian: ___________________________ Preferred Phone: ______________________
Address: ___________________________________
____

Has your child been tested or received medical or professional services for any of the following?
Developmental Disability ___ yes ___no Other Health Impairment (i.e., ADHD) ___ yes ___no
Speech Therapy ___yes ___no Seizure Disorder ___yes ___no
Other, please list: ____
What is the primary language spoken in the home? ____________________________
Does your child take any medications regularly? ____Name of meds & dosage __________________________
Does your child have any allergies? _____ If yes, please list ____
Does your child have seasonal allergies? ____yes ____no
Does your child have any food allergies? ____ Please describe ____
Is there any other information regarding your child that may be helpful to the teacher in meeting your child's needs? ____ If yes, please describe ____
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____

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

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.

Parent/Legal Custodian Signature ____ Date _________________

Section B: Completed by Physician * May attach print out. It must have doctor name & address

Immunizations	Date	Date	Date	Date	Date	Comments
DTP/DT/DtaP						
POLIO						
PCV7						
HIB						
HEP B						
MMR						
Chicken Pox						
Hearing	normal	abnormal				
Vision	normal	abnormal				

Each child entering New London Christian Preschool is required to present the following statement certifying that the child is under a physician's care, is physically able to participate in the school program, and all immunizations are up to date. Physician's statement: I have examined the above-name child within the past year and find that he/she is physically and mentally able to take part in the school's program.

____
Physician's Name Address Phone

Physician's Signature ______________________________ **(mandatory)**