HEALTH HISTORY

Child's Health Care Providers:		
Date of child's last physical exam:	Physician's Name:	Phone:
Street Address	City	Zip Code
Child's dentist's name:		Phone:
Street Address	City	Zip Code
Child's Medical Insurance Coverage:		
Insurance Company Name:	Member/policy number:	
Policy holder name:	Employer name:	
Allergies and Medication:		
Does your child have any allergies (including drug reactions)? If yes, please explain:		
Does your child take any regular medications? If yes, please explain:		

A. **DOES YOUR CHILD HAVE ANY OF THE FOLLOWING** (Please check any that apply): ☐NONE

	Frequent Colds		Frequent Sore Throats		Frequent Ear Infections
	Skin Disorders (i.e. rashes)		Heart Trouble		Convulsions
	Fainting Spells		Diabetes		Asthma
	Stomach Upsets		Urinary Difficulties		Frequent Diarrhea
	Frequent Constipation		Febrile Seizures		Other _____

Please provide details on any items marked in box **A:**

B. **HAS YOUR CHILD BEEN DIAGNOSED WITH ANY OF THE FOLLOWING** (Please check any that apply): ☐NONE

	Language Delay		ADD/ADHD		Developmental Delays
	Autism or Related Disorder		Hearing Impairment		Vision Impairment
	Learning Disabilities		Mental Illness		Behaviorial/Emotional Disorders
	Other: _____		Other: _____		Other: _____

Please provide details on any items marked in box **B:**

Please describe any other concerns you may have about your child's physical development. (For example: coordination, hearing, vision…)

Consent to medical care and treatment of minor children

I give permission that my child, _____, may be given first aid/emergency treatment by the qualified staff at The Children's Garden Preschool.

Parent/Guardian signature Date	Parent/Guardian signature Date

When I cannot be contacted, I authorize and consent to medical, surgical, and hospital care, treatment and procedures to be performed for my child by a licensed physician, health care provider, and hospital when deemed necessary or advisable by the physician to safeguard my child's health. I waive my right of informed consent to such treatment. I also give my permission for my child to be transported by ambulance to an emergency center for treatment. I certify under penalty or perjury under the laws of the State of Washington that this information is true and correct.

Parent/Guardian signature Date	Parent/Guardian signature Date