PRIMROSE HEALTH HISTORY FORM

Name of Child: (Last) _____(First)_____(DOB)_____

Male ___Female___ Mother's Name_____ Father's Name_____

Special Problems: _____

Native language spoken in the home: _____

1.
(a) Has your child ever seen an eye specialist for eye problems or defective vision?

_____

(b) If so, what was the result of the examination and recommendation, if any?

_____

2.
(a) Has your child's hearing ever been tested?

_____

(b) If so, what was the result of examination and recommendations, if any?

3.
(a) Has your child had any other medical screenings or evaluations?

Yes_____ No_____ Date_____

(b) If yes, what were the results and recommendations, if any?

_____

_____

4.
(a) Has your child ever seen a dentist?

Yes_____ No_____ Date_____

(b) If so, for what reason? _____

_____

(Please see reverse side)

5.
(a) Has your child been hospitalized at all since birth?

Yes_____ No _____ Date_____

(b) If so, what was the reason? _____

_____

(c) Any other serious illness or injuries? _____

_____

6. Does your child have any allergies?

Yes_____ No_____

Please list _____

_____

7. Is your child presently taking any medications?

Yes _____ No _____

Please list _____

_____

8. Please check if your child has a history of any of the following:

____ Asthma	**____ Fracture**
____ Chicken Pox	**____ Frequent Ear Infections**
____ Congenital Heart Failure	**____ Lyme Disease**
____ Coxsackie viruses	**____ Pneumonia/Bronchitis**
____ Diabetes	**____ Seizure**
____ Fifth's Disease	**____ Others**

Details: _____

I understand that all reports and testing results provided to Primrose School will be treated confidentially.

_____ _____

Date Parent/Guardian Signature