SUN'S INTERNATIONAL PRESCHOOL

HEALTH FORM

TO BE COMPLETED BY PARENTS.

Name: _____

(Last) (First) (Middle)

Birth: Month: _____, Day: _____, Year: _____ Age:_____

Blood Type _____

Address: _____

Zip: _____ **Tel:** _____

E-mail (PC): _____

E-mail (Mobile): _____

Father's Name: _____

Phone: _____ **Mobile:** _____

Mother's Name: _____

Phone: _____ **Mobile:** _____

To Be Called in Emergency: (If parents cannot be reached)

Name: _____ Phone: _____

Name: _____ Phone: _____

Possible medical emergencies: _____

Known health problems: _____

Taking medication? Explain: _____

_____

Is your child allergic to anything? If so What? : _____

_____

Child's Doctor's Name & Address: _____

_____ Phone: _____

Child's Dentist's Name & Address: _____

_____ Phone: _____

Is there anything else about your child that the preschool staff should be aware of in order to help and understand him / her better? : _____

_____

_____

_____

Immunization Records/Communicable Disease Records

Immunization Boosters	Year	Year	Year
Diphtheria			
Tetanus			
Pertussis			
Polio			
Mumps			
Measles			
German Measles			
BCG			
TB Test			

Communicable Disease	Year

Health History

	Year
Asthma	
Other Allergies	
Epilepsy	
Surgery	
Serious Injury	