



PRESCHOOL HEALTH QUESTIONNAIRE

Child Name:	
Address:	
Age:	Birthdate:

Child's Future School			
Circle One:	Field Park	Forest Hills	Laidlaw
Other:			

Parent's Name:
Telephone Number:

CURRENT HEALTH INFORMATION:
Family Practice/Pediatrician:
Date of Most Recent Physical Exam:
Does your child have any medical concerns or needs?
Eye Problems or Injuries:
Chronic Ear Problems or Hearing Loss:
Allergies (Please List):
Any Complications at Birth (Please Explain):
Serious Illnesses, Accidents, Surgeries, or Extended Hospitalizations (Please List):
Does your child take any daily medications? (Please List):