HARBOUR POINTE CHRISTIAN PRESCHOOL HEALTH HISTORY

_____ _____
STUDENT'S FIRST NAME STUDENT'S LAST NAME

Sex: ____Male ____Female

Child's Physician_____ Phone #_____
Clinic Address:_____

Date of Child's Last Physical Exam_____

Share any health concerns or chronic medical conditions that you believe would be important for ***SCHOOL NAME*** and its staff to know while your child is in our care:

_____
_____

Allergies: Check all that apply: ____Foods ____Plants ____Bee/Insects ____Animals ____Other

List Food/Other Allergies:

FOOD/OTHER **ALLERGIC REACTION**

_____
_____
_____
_____

If Signs of a reaction occur, please list instructions of how you would like us to respond, in order.

1. _____
2. _____
3. _____

Is medication or Epi-Pen needed for allergy? ____YES ____NO

If medications and/or an epi-pen will be needed to administer to a child in an emergency situation, we need to have a current Doctor's prescription with instructions for dosage and circumstances under which medication is to be administered. We need to have the medication at school at all times and labeled with your child's name in a baggie. A conference with staff is required each year your child is enrolled.

Other than allergy, does your child have any food restriction?
(Cultural, Religious, Personal)? ____no ___yes, describe:

_____
_____

*You may need to bring a snack for your child every day in case they cannot eat the classroom snack provided by the other parents. Please communicate with your child's teachers about this.

Is your child taking medication at home for any ongoing condition? ____no ____yes

If yes, please describe:_____

HAS YOUR CHILD:

Had a hearing test? ____yes ____no Please list any concerns:_____

Had an eye exam? ____yes ____no Please list any concerns:_____

Had a speech/communication evaluation? ____yes ____no Please list any concerns:_____

Is your child currently receiving speech therapy? ____no ___yes

Do you have any concerns about your child's behavior? ____no ____yes, describe:

_____

_____

Do you have any concerns about your child's development? ____no ____yes, describe:

_____

_____

ADDITIONAL CONCERNS:

_____

_____

_____

DENTAL HISTORY

Name of Dentist :_____City/State_____Phone_____

Has your child seen a dentist? ____no ____yes

_____ _____

Signature of Parent or Guardian Date

CONSENT TO MEDICAL CARE AND TREATMENT OF MINOR CHILD

I hereby give permission that my child, _____
may be given treatment by a qualified ***Harbour Pointe Christian Preschool*** employee at ***Harbour Pointe Christian Preschool***. 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, hospital or emergency technician (EMT) when deemed necessary or advised by the physician or EMT 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 or aid car to an emergency center for treatment.

_____ _____

Parent/Guardian Signature Date Parent/Guardian Signature Date