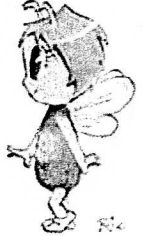




# LITTLE BUNDLE BEE DAYCARE



## Child's Health Record

Child's Name: \_\_\_\_\_ Birth Date: \_\_\_\_\_ Sex: \_\_\_\_\_

Does your child have any of the following?

Known Allergies /Sensitivities

Check One If "Yes", please describe below:

Medications:  Yes  No

Foods:  Yes  No

Other:  Yes  No

Has your child ever had any of the illnesses listed below?

Chicken Pox  Yes  No Date: \_\_\_\_\_ Measles  Yes  No Date: \_\_\_\_\_

Whooping Cough  Yes  No Date: \_\_\_\_\_ German Measles  Yes  No Date: \_\_\_\_\_

Mumps  Yes  No Date: \_\_\_\_\_ Rubella  Yes  No Date: \_\_\_\_\_

Rheumatic Fever  Yes  No Date: \_\_\_\_\_ Scarlet Fever  Yes  No Date: \_\_\_\_\_

Does your child frequently suffer from any of the following?

Headaches  Yes  No Ear Infections  Yes  No

Sore Throats  Yes  No Upset Stomach  Yes  No

Other (please describe): \_\_\_\_\_

Does your child have any of the following?

Visual Impairment  Yes  No Physical Impairment  Yes  No

Hearing Impairment  Yes  No Emotional Problems  Yes  No

Please provide details here: \_\_\_\_\_

Has your child had any surgeries?  Yes  No

If you answered "Yes" above, please give details with dates below: \_\_\_\_\_

Are all of your child's required immunizations current?  Yes  No

If you answered "No" above, please list which immunizations are needed \_\_\_\_\_

My child's Medical Provider is: \_\_\_\_\_

Name: \_\_\_\_\_

Address: \_\_\_\_\_

Phone: \_\_\_\_\_