

**HAPPY HOUSE DAYCARE COLD LAKE ALBERTA
HEALTH HISTORY FORM**

Child's Name: _____
FIRST MIDDLE LAST

Date of Birth: _____ Sex: M / F

Doctor's Name _____ Birth Weight: _____

Address: _____

Home Phone Number: _____

Mothers'/Guardian's Name _____ Alternate Phone Number: _____

Father's/Guardian's Name: _____ Alternate Phone Number: _____

Child's immunization up to date? Yes _____ No _____ Last date of immunization: _____

Where was your child last immunized? _____
Name of clinic Address/City

If your child has any of the following illnesses/conditions, please check (x) and provide detail:

Allergies Heart Trouble Diabetes
 Asthma Epilepsy Convulsions (*not due to Epilepsy*)

Other: _____

Comments: _____

Has your child had any of the following childhood diseases?

Chicken Pox German Measles Red Measles
 Mumps Strep Throat Other: _____
 Impetigo Pin worms

Has your child experienced any of the following?

Difficulty with speech Yes/No 3 or more earaches Yes/No
 Difficulty with hearing Yes/No Eating or sleeping problems Yes/No
 Difficulty with eyesight Yes/No Day time or bed wetting

Comments: _____

It is helpful to know if you are concerned about your child's behaviour.

Please check (x) any of the following behaviours your child may exhibit that worry you.

Frequent fights and /or temper tantrums: _____
Restless, always moving, short attention span _____
Nervous, shy or timid _____
Has few friends, plays mostly alone/independently _____
Other: _____
Comments: _____

Please indicate if you have any other concerns about your child's physical or emotional health:

Is your child on any medication **Yes / No**
If yes, please specify the name of the medication and the reason your child is receiving it.

Has your child ever been hospitalized, had surgery or been treated in the emergency room? Yes/No
If yes, please explain:

Additional Comments:



Parent/Guardian Printed Name

Date

Parent/Guardian Signature