Sioux City Community School District

PRESCHOOL REGISTRATION CHILD MEDICAL HISTORY INFORMATION

Information to be filled out by parent/guardian:

Name of child: _____ Birthdate: _____

Name of parents/guardian: _____

With whom does the child live: Mother ( ) Father ( ) Guardian_____ Other_____

Has your child EVER had any of the following conditions:

	YES	NO	AGE
Chicken Pox			
Asthma			
Diabetes			
Seizures			
Heart Problem			
Meningitis			
Pneumonia			
TB Infection			
Bowel Problem			
Allergy			
Cancer			
Ear Tubes			
Hepatitis			
Measles			
Mumps			
Skin Problem			
Hearing Problem			
Vision Problem			

Anything the school should know about the above health conditions or other health conditions: _____

_____

Child's General Health Information

Has the child been hospitalized? Yes ( ) No ( ) If yes, explain with dates: _____

_____

Is child on any medications? Yes ( ) No ( ) If yes, list name, dose, time and reason: _____

_____

Will the child need to take any medication at school: Yes ( ) No ( )

Has the child had any surgeries? Yes ( ) No ( ) If yes, explain with dates: _____

_____

Does the child have any physical activity restrictions? Yes ( ) No ( ) If yes, describe: _____

_____

Child's Medical Exams

Date of last physical exam: _____ Dr. _____ Results _____

Date of last dental exam: _____ Dr. _____ Results _____

Date of last vision exam: _____ Dr. _____ Results _____

Does you Child have current insurance?

Health: Insurance Provider Name _____ Policy Number _____

Dental: Insurance Provider Name _____ Policy Number _____

Vision: Insurance Provider Name _____ Policy Number _____

Signature of parent/guardian _____ Date _____